METROPOLITAN
HEALTH INSURANCE FUND

AGENDA AND REPORTS
JANUARY 15, 2026
ZOOM
CONFERENCE CALL
12:00 PM

Zoom Meeting
https://permainc.zoom.us/j/92266405954

Meeting ID: 922 6640 5954
+13092053325,,92266405954# US
+13126266799,,92266405954# US (Chicago)

OPEN PUBLIC MEETINGS ACT - In accordance with the Open Public Meetings Act, notice of this meeting was given by:

I. Sending sufficient notice to **The Record and The Star Ledger**
II. Filing advance written notice of this meeting with the Clerk/Administrator of each member municipality and school boards,
III. Posting notice on the Public Bulletin Board of all member municipalities and school boards.
IV. During the business session portion of this Remote Public Meeting, the audio of all members of the public meeting will be muted. At the end of the business session of the meeting, a time for public comment will be available. Members of the public who desire to provide comment shall raise their virtual hand in the Zoom application and/or submit a written comment via the text message section of the application. The meeting moderator will queue the members of the public that wish to provide comment and the Chairperson will recognize them in order. Public comment shall be concise and to the point, and shall not contain abusive, defamatory, or obscene language.

METROPOLITIAN HEALTH INSURANCE FUND
AGENDA MEETING: JANUARY 15, 2026
CONFERENCE CALL - ZOOM
12:00 PM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

Fund Commissioner	**Entity**
Jenny Mundell, Chairwoman	Bloomfield Public Library
Kimberly Duva, Secretary	Bloomfield Township
Cameron Cox, Executive Committee Member	Plainfield Public Schools
Nikole Baltycki, Executive Committee Member	West Caldwell Township
Chris Hartwyk, Executive Committee Member	City of Orange
Margaret Heisey, Executive Committee Member	Scotch Plains Twp
Patrick Wherry, Executive Committee Member	Maplewood Township

APPROVAL OF MINUTES, November 10, 2025 ..... Appendix I
November 12, 2025 Finance Committee..... Appendix II
November 24, 2025 Finance Committee.....Appendix III

ADJOURN SINE DIE MEETING

MEETING OF FUND COMMISSIONERS CALLED TO ORDER

ROLL CALL OF ALL 2026 FUND COMMISSIONERS

ELECTION OF OFFICERS, EXECUTIVE COMMITTEE & ALTERNATES
Executive Director asks for nominations.

RECOMMENDED SLATE

Fund Commissioner	**Entity**
Jenny Mundell, Chairwoman	Bloomfield Public Library
Patrick Wherry, Secretary	Maplewood Township
Cameron Cox, Executive Committee Member	Plainfield Public Schools
Nikole Baltycki, Executive Committee Member	West Caldwell Township
Chris Hartwyk, Executive Committee Member	City of Orange
Margaret Heisey, Executive Committee Member	Scotch Plains Twp
Alexander McDonald , Executive Committee Member	Millburn Township

ROLL CALL OF 2026 FUND COMMISSIONERS TO ELECT OFFICERS AND EXECUTIVE COMMITTEE

OATH OF OFFICE – *Appendix IV*

ROLL CALL OF 2026 EXECUTIVE COMMITTEE

CORRESPONDENCE – Department of Banking and Insurance: Questionnaire and Response

FUND EXECUTIVE DIRECTOR – PERMA

FUND COODINATOR – Eagle Rock Management Group

FUND ATTORNEY – Antonelli Kantor Rivera PC

FUND TREASURER – Laracy Associates

THIRD PARTY ADMINISTRATOR – Aetna

PRESCRIPTION PROVIDER – Express Scripts

DENTAL ADMINISTRATOR – Delta Dental

OLD BUSINESS

NEW BUSINESS

PUBLIC COMMENT

Motion to Open
Motion to Close

MEETING ADJOURNED

Metropolitan Health Insurance Fund
Executive Director's Report
January 15, 2026

FINANCES

PRO FORMA REPORTS

- **Fast Track Financial Reports –** As of September 30, 2025 and October 31, 2025 (page 15)
  - **Historical Income Statement**
  - **Consolidated Balance Sheet**
  - **Indices and Ratios Report**

ADMINISTRATION

2026 ORGANIZATIONAL RESOLUTIONS

A consent agenda has been included with the necessary resolutions for the Fund to operate for the year. The following resolutions are included:

Resolution 1-26 awards professional contracts and compensation, as per the approved budget and RFP responses. This resolution will be advertised as per the public contracts law.

Resolution 2-26: Designation of Service Process elects PERMA.

Resolution 3-26: Designates the elected Secretary as the Custodian of Fund Records. All records are retained at the Administrator's office which handles all OPRA requests on behalf of the Secretary.

Resolution 4-26 Designates the Star Ledger and The Record as the Official Fund Newspaper. Effective March 1, 2026, the Fund may keep all public notices on the Fund website. The newspaper will issue the notice with a link to the Fund's website twice a month.

Resolution 5-26 Sets meeting dates and times which will be posted on each entity's public bulletin board. The Fund will meet virtually or in person as listed in the resolution.

Resolution 6-26 Sets for the Cash Management Plan and bank depositories for 2026. The Cash Management Plan is a standard banking and investment policy and procedure that is used in other Joint Insurance Funds administered by PERMA. This plan has been reviewed by the Treasurer. Recommended updates have been included for acceptance:

Monthly Billing Policy – Although it has been followed over the past year, this policy is being documented in the Risk Management Plan

Resolution 7-26 Unless the Committee decides otherwise, the same signatories will continue for 2026 for the Fund operating account checks.

Resolution 8-26 is the 2026 Risk Management Plan which outlines the Fund's stop loss limits, underwriting procedures, claim appeal processes, etc. Recommended updates have been included for acceptance:

Out of Network Appeal Process – In light of the Out of Network change, an appeal process has been established and included for documentation purposes.

Resolution 9-26: The Fund will need to elect a Commissioner and Alternate to represent the Metro Fund at the Municipal Reinsurance Health Insurance Fund. 2025 representatives are Commissioner Cox and Nickole Baltycki if they wish to continue for the 2026 Fund Year.

Resolution 10-26 adopts the broker fees for each entity. Broker commissions will be paid directly to the firm through the Fund. Each entity's rates reflect its arrangement only.

Resolution 11-26 authorizes the Treasurer to pay contract fees and expenses during the months that the Fund does not meet, contingent upon ratification at the next meeting.

COMMITTEE APPOINTMENTS

Sub Committees are typically appointed by the Fund Chair, although they may be appointed at the direction of the Executive Committee. The Fund would like to fill the following committees with no more than 3 Commissioners. The Chairperson will always sit Ex Officio:

Finance & Contracts	**Wellness**	**Operations and Nominations**
Cameron Cox	Patrick Wherry	Margaret Heisey
Nikole Baltycki	Open	Stephen Marks
Patrick Wherry	Open	Cosmo Cirillo

Motion: *Motion to approve the Subcommittee appointments.*

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND – MEETING REPORT

The MRHIF met on December 10. Commissioner Cox was in attendance. Its major action item was to adopt its 2026 Budget as it was introduced in September.

The Express Scripts contract through the Level Pharmacy Coalition was extended for one final year due to the inability to issue a formal RFP. The Fund expects to begin that process in early spring for 2027.

The Commissioners were also provided an update on the Audit of Express Scripts claims from 2024 which should be starting shortly.

CORRECTION OF RESOLUTION NUMBER ASSIGNMENT

It was recently discovered that Resolution No. 27-25 was inadvertently assigned to two separate actions - One in the Special October meeting and another in the November meeting. To maintain accurate records, it is recommended that the Budget Adoption resolution be renumbered as Resolution No. 31-25, which is the next available number. Resolution No. 12-26 approves this change.

SUPPLEMENTAL ASSESSMENT – INTRODUCTION

During the November 24th meeting of the Finance Committee, the committee is recommending a $7M Supplemental Assessment, which was approved by the Finance Committee and is believed adequate and justified. We are recommending the Fund begin collection of the Supplemental Assessments following adoption in January 2026. The billing of required amounts would take effect no later than March 1, 2026. The 2026 budget is developed to be self-sustaining and further contribute to surplus regeneration. As this is the case, we would be comfortable with the collection period going as far as 36 months from the start date. If the Fund position improves to a level of adequacy and comfort prior to the end of the 36-month period, the Executive Committee has the discretion to suspend the remaining payments/assessments.

Alternatively, if a group can satisfy 90% of their adopted supplemental assessment by June 30, 2026, the Fund will consider the liability satisfied. This assumes the following schedule of events:

1) ***Introduction of Supplemental Assessment: January 15, 2026***
2) ***Adoption and early collection of Supplemental Assessment: February 19, 2026***
3) ***Initial installments begin: March 1, 2026***
4) ***Final installments due no later than February 29, 2028***

METRO Supplemental Assessment				
$7,000,000- *All of 2024 Deficit and Portion of Closed Year (as of 7/31/25)*				
	GRAND TOTAL FY 2024 AND CLOSED YEAR Net surplus/	Monthly payments		
Member	Cash Collection	12 months	24 months	36 months
Bloomfield Township	$ 1,693,493.65	$ 141,124.47	$ 70,562.24	$ 47,041.49
Bloomfield Library	$ 40,883.14	$ 3,406.93	$ 1,703.46	$ 1,135.64
East Amwell	$ 5,463.74	$ 455.31	$ 227.66	$ 151.77
Maplewood	$ 304,436.45	$ 25,369.70	$ 12,684.85	$ 8,456.57
Orange	$ 1,196,389.12	$ 99,699.09	$ 49,849.55	$ 33,233.03
Plainfield BOE	$ 3,155,687.78	$ 262,973.98	$ 131,486.99	$ 87,657.99
Scotch Plains	$ 328,562.77	$ 27,380.23	$ 13,690.12	$ 9,126.74
West Caldwell	$ 275,083.76	$ 22,923.65	$ 11,461.82	$ 7,641.22
	$ 7,000,000.41	$ 583,333.37	$ 291,666.68	$ 194,444.46

The Supplemental Assessment collection will be used to pay outstanding fees and premiums, including amounts owed to vendors, starting with payments to the Fund Executive Director and the Municipal Reinsurance Health Insurance Fund.

Resolution 13-26 is included for action, and a public hearing will be held on February 19, 2026.

POPULATION HEALTH RFP

At the direction of the Fund's QPA, the previously issued RFP 25-03, for population health/wellness services, is no longer valid under the timeline rules of Competitive Contracting. The Wellness Committee will re-evaluate the matter in the new year. The 2026 budget includes an allotment for wellness, which could be considered for future procurement.

QUALIFIED PURCHASING AGENT (QPA) - 2026 QUOTES

As authorized by the Executive Committee, PERMA will prepare a solicitation for quotes for QPA services for the 2026 fund year. Commissioners are encouraged to submit any recommendations for professionals to be included in the solicitation process.

NEW MEMBERS

There are currently two prospective Medicare Advantage Only Members who have not yet finalized their resolutions or I&T agreements but are actively considering participation in the METRO Fund – The **City of Paterson** and **Passaic City**. The Underwriting details are below. Both entities are evaluating membership with a potential effective date of February 1, 2026. Resolution 14-26 has been prepared to approve their membership, contingent upon the completion and submission of all required documents.

New Member Overview	
Fund	Metropolitan Health Insurance Fund
Entity	Passaic City
County	Passaic
Effective Date	2/1/2026 - 12/31/2026
Lines of Coverage	Medicare Advantage Only
Eligible Employees	563
Retiree Coverage	Yes - Under & Over 65 Coverage
Current Arrangement	SHBP
Actuary Certification	N/A
Run Out Claims	
Broker	
Member approval?	Awaiting I&T Agreement / Resolutions
Per employee Perm Month	$380 Per Retiree
Special Requests	None

New Member Overview	
Fund	Metropolitan Health Insurance Fund
Entity	City of Paterson
County	Passaic
Effective Date	2/1/2026 - 12/31/2026
Lines of Coverage	Medicare Advantage Only
Eligible Employees	571
Retiree Coverage	Yes - Under & Over 65 Coverage
Current Arrangement	SHBP
Actuary Certification	N/A
Run Out Claims	
Broker	
Member approval?	Awaiting I&T Agreement / Resolutions
Per employee Perm Month	$318 Per Retiree
Special Requests	None

2026 PERMA MANAGEMENT TEAM UPDATES

As we continue to prepare for the future, the Executive Director's office must continue to adapt and operate and maximum productivity. As of January 1, 2026, Mr. Brandon Lodics transitioned into the role overseeing the financial strategy and performance of the Funds while also focusing on new products and services that can be implemented. Mr. Jim Rhodes has transitioned into the Executive Director, who will oversee day-to-day management, regulatory, and governance.

We are excited as this update to the Executive Director's office will allow us to continue to operate at maximum capacity, focusing on financial management and governance while being mindful of the complexities of the business.

DEPARTMENT OF BANKING AND INSURANCE RESPONSE

The Department of Banking and Insurance (DOBI) reached out in response to our 2026 budget filings with a questionnaire that allows them to gain a better understanding of the Fund. A letter of the response from PERMA has been included in ***APPENDIX II***, which has been reviewed by the Chair and Fund Attorney prior to sending.

NEW JERSEY HEALTH INSURANCE FUND MARKETING UPDATE

PERMA is pleased to unveil a new and refreshed online branding and marketing landing page for the NJ Health Insurance Funds, where our firm is privileged to serve as the appointed Executive Director. This replaces the Hi Fund website, providing an easy to navigate gateway to your Health Insurance Fund.

This new rebrand reflects PERMA's excitement and optimism for the future, showing our commitment to the on-going mission of delivering high value, affordable, and stable health benefit solutions.

GASB 75 REPORTING

The Fund is contracted with an actuary to prepare GASB 75 reports for its medical members. If your audit requires a complete report or an update to the previous year's report, please contact Jordyn Robinson at jrobinson@permainc.com. Please note that during peak periods, report turnaround time may be up to six weeks.

INDEMNITY AND TRUST AGREEMENTS

PERMA sent Indemnity and Trust Agreements and Resolutions for adoption by the governing bodies to renew membership with the Fund for an additional 3 years. Below is a list of members with renewing agreements that have expired. Please reach out to hifadmin@permainc.com for a blank form to be executed. The list was last updated on December 23, 2025.

Member	**I&T End Date**
Town of Morristown	6/30/2025
Maplewood Township	12/31/2025
Millburn	12/31/2025
Bloomfield Library	12/31/2026
Bloomfield Twp	12/31/2026
Irvington	12/31/2026
Scotch Plains	12/31/2026
West Caldwell	12/31/2026
West Orange	12/31/2026
Plainfield BOE	6/30/2027

City of Orange	12/31/2027
East Orange	12/31/2027
Town of Guttenberg	12/31/2027
Union Township	12/31/2027
East Hanover Township	12/31/2027
Montclair	12/31/2028
Town of Secaucus	12/31/2028
Chester Twp	
East Amwell	

BENEFITS

Conner Strong & Buckelew Program Manager Team

Tammy Brown	Public Entity & HIF Business Leader	856-552-4694	tbrown@connerstrong.com
John Lajewski	HIF Business Leader	856-552-4922	jlajewski@connerstrong.com
Melissa Appleby	Associate Consultant	732-736-5268	mappleby@connerstrong.com
Sean Critchley, Esq.	Senior Business Development Executive	973-736-6511	scrichley@connerstrong.com

Agenda

- Industry Update
- Fund Performance/Observations
- Client Services/Eligibility/Enrollment
- Previously Reported Information

Industry Updates

- Food and Drug Administration approved the first oral version of Wegovy, Novo Nordisk's blockbuster GLP-1 weight-loss drug. This marks the first GLP-1 approved for weight loss in pill form. A competing oral GLP-1 from Eli Lilly is expected to receive approval in the coming months.

Fund Performance/Observations

Medical - Aetna

- Effective August 1, 2025, the Metro Fund Executive Committee passed a resolution to unilaterally amend the out of network provider reimbursement schedules for all Fund member plans to 150%-provider & 175%-facility of Medicare. This action was taken to address the escalating out of network provider utilization and their disproportionate reimbursement levels. Early results of the schedule change suggest reduced levels of out-of-net network utilization. Out-of-net network utilization will continue to be monitored monthly and reported to the Executive Committee.

Pharmacy – Express Scripts (ESI)

- Absent plan changes, it is clear the Fund needs to address the rising utilization and associated costs with GLP-1 medications used specifically for weight loss. The following strategies are being evaluated for their efficacy and will be presented formally upon the conclusion of the evaluation.
    - Implement tighter, clinically grounded utilization management protocols for GLP-1 medications used specifically for weight loss
    - Plan design options to exclude GLP-1 medications for weigh loss on the Fund member level
    - Plan design options for increased member cost share for GLP-1 medications for weigh loss on the Fund member level
    - Direct to consumer GLP-1 acquisition channel options

Client Services/Eligibility/Enrollment Team

Crystal Bailey	Director of Client Services	856-552-4914	cbailey@connerstrong.com
Karen Kidd	Director of Benefits Operations	856-552-4644	kkidd@connerstrong.com
Peter Moore	Client Service Specialist	856-479-2158	pmoore@permainc.com

- Please direct all service requests to both Peter Moore and Crystal Bailey effective immediately. All outstanding service requests will be addressed and resolved by Peter and Crystal.
- System training (new and refresher) is provided to all contacts with WEX access every 3rd Wednesday at 10AM. Please contact HIFtraining@permainc.com for additional information or to request an invite.

Carrier Appeals:

Submission Date	Appeal Type	Appeal Number	Reason	Determination	Determination Date
11/04/2025	Medical/Aetna	METRO 2025 11 01	Injection	Upheld	11/21/2025
11/06/2025	Medical/Aetna	METRO 2025 11 02	Anesthesia	Upheld	11/23/2025
11/11/2025	Medical/Aetna	METRO 2025 11 03	Inpatient Stay	Upheld	12/05/2025
12/01/2025	Medical/Aetna	METRO 2025 12 01	In-Home Nursing	Upheld	12/10/2025
12/03/2025	Medical/Aetna	METRO 2025 12 02	Anesthesia	Upheld	12/10/2025

IRO Submissions:

Submission Date	Appeal Type	Appeal Number	Reason	Determination	Determination Date
12/05/2025	Medical/Aetna	METRO 2025 11 03	Inpatient Stay	Under Review	
12/10/2025	Medical/Aetna	METRO 2025 12 01	In-Home Nursing	Under Review	

Previously Reported Information

Express Scripts

- 2026 National Preferred Formulary (NPF) – Effective 1/1/2026
- NPF Exclusions list– Effective 1/1/2026
- SaveOn List – Effective 1/1/2026

All impacted members were sent communications from ESI letting them know about the upcoming change(s) to their medications. The communications also include preferred alternatives medication(s). We recommend impacted members share the communication with their provider to discuss next steps. Those that are unable to take the preferred alternative medication(s) will need an approved PA to continue to take their current medication(s).

No Surprise Billing and Transparency Act

- Transition to State Arbitration - Effective January 1, 2026:
- As a result of the transition, enrolled members will be receiving new ID cards from Aetna prior to January 1st. subscriber ID numbers and Fund member group numbers will not be changing.

IMPORTANT FUND INFORMATION
Website: www.metrohif.com
Address: 9 Campus Drive, Suite 216, Parsippany, NJ 07054
EIN: 93-4065414
HIF Admin: hifadmin@permainc.com
HIF Admin Contacts:
James Rhodes, Executive Director, jrhodes@permainc.com
Emily Koval, Associate Executive Director, emilyk@permainc.com
Jordyn Robinson, Assistant Account Manager, jrobinson@permainc.com

NOTICE AND DISCLOSURE

TO ALL FUND COMMISSIONERS

January 2026

Pursuant to N.J.A.C Title 11, Chapter 15, Subchapter 5, Conner Strong & Buckelew Companies, LLC, as a servicing organization of the **Metropolitan Health Insurance Fund ("the Fund")**, and its employees, officers and directors hereby provide notice that they have direct and indirect financial interests in PERMA, LLC, which is the Administrator for the Fund.

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF September 30, 2025

				THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
1.	**UNDERWRITING INCOME**			**7,536,375**	**65,765,748**	**207,950,683**	**273,716,431**
2.	**CLAIM EXPENSES**						
		Paid Claims		6,922,602	61,045,001	180,131,885	**241,176,886**
		IBNR		2,141	1,035,496	6,202,000	**7,237,496**
		Less Specific Excess		(731,966)	(3,014,332)	(5,740,079)	**(8,754,411)**
		Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS			**6,192,778**	**59,066,166**	**180,593,806**	**239,659,972**
3.	**EXPENSES**						
		MA & HMO Premiums		1,013,545	9,078,630	15,510,298	**24,588,928**
		Excess Premiums		213,269	1,911,703	3,986,606	**5,898,309**
		Administrative		461,968	4,291,388	11,349,468	**15,640,855**
	TOTAL EXPENSES			**1,688,782**	**15,281,721**	**30,846,371**	**46,128,092**
4.	**UNDERWRITING PROFIT/(LOSS) (1-2-3)**			(345,185)	(8,582,139)	(3,489,494)	**(12,071,633)**
5.	**INVESTMENT INCOME**			8,408	160,088	603,103	**763,190**
6.	**DIVIDEND INCOME**			-	57,191	-	**57,191**
7.	**STATUTORY PROFIT/(LOSS) (4+5+6)**			**(336,777)**	**(8,364,860)**	**(2,886,391)**	**(11,251,252)**
8.	**DIVIDEND**			-	-	-	**-**
9.	**Transferred Surplus IN**			-	-	-	**-**
10.	**Transferred Surplus OUT**			-	-	-	**-**
	STATUTORY SURPLUS (7-8+9)			**(336,777)**	**(8,364,860)**	**(2,886,391)**	**(11,251,252)**
				SURPLUS (DEFICITS) BY FUND YEAR			
	Closed		**Surplus**	(34,152)	(443,468)	(83,541)	**(527,010)**
			Cash	72,882	(499,026)	937,859	**438,833**
	2024		**Surplus**	(88,960)	(4,737,343)	(2,802,851)	**(7,540,194)**
			Cash	864,944	(11,534,366)	2,904,238	**(8,630,128)**
	2025		**Surplus**	(213,666)	(3,184,049)		**(3,184,049)**
			Cash	393,944	11,310,594		**11,310,594**
TOTAL SURPLUS (DEFICITS)				**(336,777)**	**(8,364,860)**	**(2,886,392)**	**(11,251,252)**
TOTAL CASH				**1,331,770**	**(722,799)**	**3,842,097**	**3,119,298**
				CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS			**34,411**	**539,538**	**114,524,196**	**115,063,733**
	FUND YEAR 2024						
		Paid Claims		456,729	12,460,501	60,757,659	**73,218,160**
		IBNR		(62,020)	(6,068,657)	6,202,000	**133,343**
		Less Specific Excess		(305,556)	(1,587,632)	(890,049)	**(2,477,681)**
		Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2024 CLAIMS			**89,153**	**4,804,212**	**66,069,610**	**70,873,822**
	FUND YEAR 2025						
		Paid Claims		6,465,874	47,821,560		**47,821,560**
		IBNR		64,161	7,104,153		**7,104,153**
		Less Specific Excess		(460,821)	(1,203,298)		**(1,203,298)**
		Less Aggregate Excess		-	-		**-**
	TOTAL FY 2025 CLAIMS			**6,069,214**	**53,722,416**		**53,722,416**
COMBINED TOTAL CLAIMS				**6,192,778**	**59,066,166**	**180,593,806**	**239,659,971**

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF October 31, 2025

			THIS MONTH	*YTD CHANGE*	*PRIOR YEAR END*	*FUND BALANCE*
1.	**UNDERWRITING INCOME**		**7,378,691**	**73,144,439**	**207,950,683**	**281,095,122**
2.	**CLAIM EXPENSES**					
	Paid Claims		6,236,659	67,281,660	180,131,885	**247,413,545**
	IBNR		66,289	1,101,785	6,202,000	**7,303,785**
	Less Specific Excess		(492,081)	(3,506,412)	(5,740,079)	**(9,246,491)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS		**5,810,868**	**64,877,033**	**180,593,806**	**245,470,839**
3.	**EXPENSES**					
	MA & HMO Premiums		1,010,035	10,088,665	15,510,298	**25,598,963**
	Excess Premiums		208,621	2,120,325	3,986,606	**6,106,931**
	Administrative		436,572	4,727,960	11,349,468	**16,077,427**
	TOTAL EXPENSES		**1,655,229**	**16,936,950**	**30,846,371**	**47,783,321**
4.	**UNDERWRITING PROFIT/(LOSS) (1-2-3)**		(87,405)	(8,669,544)	(3,489,494)	**(12,159,038)**
5.	**INVESTMENT INCOME**		15,541	175,629	603,103	**778,731**
6.	**DIVIDEND INCOME**		-	57,191	-	**57,191**
7.	**STATUTORY PROFIT/(LOSS) (4+5+6)**		**(71,864)**	**(8,436,725)**	**(2,886,391)**	**(11,323,116)**
8.	**DIVIDEND**		-	-	-	**-**
9.	**Transferred Surplus IN**		-	-	-	**-**
10.	**Transferred Surplus OUT**		-	-	-	**-**
	STATUTORY SURPLUS (7-8+9)		**(71,864)**	**(8,436,725)**	**(2,886,391)**	**(11,323,116)**
			SURPLUS (DEFICITS) BY FUND YEAR			
	Closed	**Surplus**	36,638	(406,831)	(83,541)	**(490,372)**
		Cash	262,822	(236,205)	937,859	**701,654**
	2024	**Surplus**	1,161	(4,736,182)	(2,802,851)	**(7,539,033)**
		Cash	(331,952)	(11,866,318)	2,904,238	**(8,962,080)**
	2025	**Surplus**	(109,663)	(3,293,712)		**(3,293,712)**
		Cash	(1,027,279)	10,283,315		**10,283,315**
TOTAL SURPLUS (DEFICITS)			**(71,864)**	**(8,436,725)**	**(2,886,392)**	**(11,323,116)**
TOTAL CASH			**(1,096,409)**	**(1,819,208)**	**3,842,097**	**2,022,889**
			CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS		**(36,091)**	**503,446**	**114,524,196**	**115,027,642**
	FUND YEAR 2024					
	Paid Claims		332,292	12,792,793	60,757,659	**73,550,452**
	IBNR		(49,616)	(6,118,273)	6,202,000	**83,727**
	Less Specific Excess		(283,497)	(1,871,129)	(890,049)	**(2,761,178)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2024 CLAIMS		**(821)**	**4,803,391**	**66,069,610**	**70,873,001**
	FUND YEAR 2025					
	Paid Claims		5,904,367	53,725,928		**53,725,928**
	IBNR		115,905	7,220,058		**7,220,058**
	Less Specific Excess		(172,492)	(1,375,790)		**(1,375,790)**
	Less Aggregate Excess		-	-		**-**
	TOTAL FY 2025 CLAIMS		**5,847,780**	**59,570,196**		**59,570,196**
COMBINED TOTAL CLAIMS			**5,810,868**	**64,877,033**	**180,593,806**	**245,470,839**

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

METRO HEALTH INSURANCE FUND

RATIOS

		FY2025									
INDICES	**2024**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**
Cash Position	3,842,097	$ 6,460,472	$ 7,124,681	$ 7,213,488	$ 4,709,181	$ 3,648,060	$ 939,137	$ 3,616,771	$ 1,787,528	$ 3,119,298	$ 2,022,889
IBNR	6,202,000	$ 6,379,664	$ 6,567,209	$ 6,793,798	$ 6,917,052	$ 6,986,595	$ 7,037,466	$ 7,195,526	$ 7,235,355	$ 7,237,496	$ 7,303,785
Assets	5,041,139	$ 4,666,942	$ 5,010,026	$ 4,759,502	$ 1,982,800	$ (427,505)	$ 126,652	$ 61,026	$ (1,166,235)	$ (1,174,024)	$ (833,055)
Liabilities	7,927,531	$ 8,444,978	$ 8,687,019	$ 8,983,617	$ 9,183,079	$ 9,307,480	$ 9,401,559	$ 9,442,603	$ 9,748,239	$ 10,077,228	$ 10,490,061
Surplus	(2,886,392)	$ (3,778,036)	$ (3,676,994)	$ (4,224,114)	$ (7,200,279)	$ (9,734,985)	$ (9,274,908)	$ (9,381,577)	$ (10,914,474)	$ (11,251,252)	$ (11,323,116)
Claims Paid -- Month	6,252,986	$ 6,353,824	$ 5,319,100	$ 5,908,283	$ 8,209,760	$ 8,059,501	$ 6,355,228	$ 6,315,245	$ 7,601,458	$ 6,922,602	$ 6,236,659
Claims Budget -- Month	4,614,842	$ 5,324,120	$ 5,465,452	$ 5,465,942	$ 5,474,485	$ 5,479,557	$ 5,483,301	$ 5,698,303	$ 5,690,979	$ 5,652,727	$ 5,752,404
Claims Paid -- YTD	72,784,814	$ 6,353,824	$ 11,672,924	$ 17,581,207	$ 25,790,967	$ 33,850,468	$ 40,205,696	$ 46,520,941	$ 54,122,399	$ 61,045,001	$ 67,281,660
Claims Budget -- YTD	62,899,992	$ 5,324,120	$ 10,789,572	$ 16,231,412	$ 21,709,638	$ 27,183,256	$ 32,645,163	$ 38,340,877	$ 44,031,856	$ 50,009,328	$ 55,761,806
RATIOS											
Cash Position to Claims Paid	0.61	1.02	1.34	1.22	0.57	0.45	0.15	0.57	0.24	0.45	0.32
Claims Paid to Claims Budget -- Month	1.35	1.19	0.97	1.08	1.5	1.47	1.16	1.11	1.34	1.22	1.08
Claims Paid to Claims Budget -- YTD	1.16	1.19	1.08	1.1	1.2	1.3	1.2	1.21	1.23	1.22	1.21
Cash Position to IBNR	0.62	1.01	1.08	1.06	0.68	0.52	0.13	0.50	0.25	0.43	0.28
Assets to Liabilities	0.64	0.55	0.58	0.53	0.22	-0.05	0.01	0.01	-0.12	-0.12	-0.08
Surplus as Months of Claims	(0.63)	(0.71)	(0.67)	-0.77	-1.32	-1.78	-1.69	(1.65)	-1.92	-1.99	-1.97
IBNR to Claims Budget -- Month	1.34	1.20	1.20	1.24	1.26	1.28	1.28	1.26	1.27	1.28	1.27

METRO Fund
2025 Budget Report
as of October 31, 2025

	Cumulative	Annualized	Latest filed	Cumulative	$ Variance	% Variance
Expected Losses				Expensed		
Medical Claims Aetna	52,176,691	62,971,785	53,539,937	55,896,691	(3,720,000)	-7%
Prescription Claims - Excl Bloomfield	3,322,874	3,982,602	1,961,095	2,485,375	(151,579)	-6%
Prescription Formulary Rebates	(1,063,321)	(1,274,433)	(627,550)	Included Above in Prescription Claims		
Prescription Claims - Bloomfield	74,243	89,519	87,552	Included Above in Prescription Claims		
Dental Claims	1,251,319	1,514,625	1,023,681	1,188,130	63,189	5%
Subtotal	55,761,806	67,284,097	55,984,715	59,570,196	(3,808,390)	-7%
HMO/DMO Premiums	28,300	34,217	27,646	51,941	(23,642)	-84%
Medicare Advantage / EGWP	10,023,588	12,069,620	9,304,294	10,036,724	(13,136)	0%
Reinsurance						
Specific	2,122,692	2,552,913	2,158,296	2,120,325	2,368	0%
Total Loss Fund	67,936,386	81,940,848	67,474,950	71,779,186	(3,842,800)	-6%
Surplus Retention Regeneration	666,667	800,000	800,000	0	666,667	0%
Expenses						
Legal	25,500	30,600	30,600	64,290	(38,790)	-152%
Treasurer	18,615	22,338	22,338	22,500	(3,885)	-21%
Administrator/Benefits Consultant	780,230	938,550	793,661	780,032	199	0%
Risk Management Consultants	1,539,888	1,852,655	1,553,293	1,529,888	10,000	1%
Fund Coordinator	778,722	937,321	748,272	778,488	234	0%
TPA - Claims Agent Aetna	957,105	1,151,088	1,021,816	901,815	55,291	6%
Dental TPA	65,544	79,298	48,737	65,517	27	0%
Actuary	14,875	17,850	17,850	17,850	(2,975)	-20%
Auditor	18,700	22,440	22,440	18,700	-	0%
Benefits Consultant						
Board Advisor						
Claims Audit	33,333	40,000	40,000	0	33,333	100%
Medicare Advantage Implementation	0	0	0	0	-	
Subtotal Expenses	4,232,513	5,092,141	4,299,008	4,179,080	53,433	1%
Miscelleneous and Special Services						
Misc/Cont	15,040	18,048	18,048	6,772	8,268	55%
Wellness, Disease, Case Management	83,333	100,000	100,000	58,174	25,159	30%
Affordable Care Act Taxes	13,017	15,655	13,235	24,270	(11,253)	-86%
A4 Surcharge	551,747	670,222	638,598	498,286	53,461	10%
Plan Documents	8,333	10,000	10,000	0	8,333	100%
Subtotal Misc/Sp Svcs	671,471	813,924	779,881	587,502	83,969	13%
Total Expenses	4,903,984	5,906,065	5,078,888	4,766,582	137,402	3%
Total Budget	73,507,036	88,646,914	73,353,839	76,545,767	(3,038,731)	-4%

Metro Municipal Employee Benefits Fund
CONSOLIDATED BALANCE SHEET
AS OF OCTOBER 31, 2025
BY FUND YEAR

	METRO 2025	METRO 2024	CLOSED YEAR	FUND BALANCE
ASSETS				
Cash & Cash Equivalents	10,283,315	(8,962,080)	701,654	2,022,889
Assesstments Receivable (Prepaid)	(4,338,021)	(279,096)	2,534	(4,614,584)
Interest Receivable	-	-	2,258	2,258
Specific Excess Receivable	633,313	589,053	-	1,222,367
Aggregate Excess Receivable	-	-	-	-
Dividend Receivable	-	-	-	-
Prepaid Admin Fees	-	-	-	-
Other Assets	534,015	1,196,818	(1,196,818)	534,015
Total Assets	7,112,622	(7,455,306)	(490,372)	(833,055)
LIABILITIES				
Accounts Payable	2,901,701	0	-	2,901,701
IBNR Reserve	7,220,058	83,727	-	7,303,785
A4 Retiree Surcharge	259,413	-	-	259,413
Dividends Payable	-	-	-	-
Retained Dividends	-	-	-	-
Accrued/Other Liabilities	25,162	-	-	25,162
Total Liabilities	10,406,334	83,727	-	10,490,061
EQUITY				
Surplus / (Deficit)	(3,293,712)	(7,539,033)	(490,372)	(11,323,116)
Total Equity	(3,293,712)	(7,539,033)	(490,372)	(11,323,116)
Total Liabilities & Equity	7,112,622	(7,455,306)	(490,372)	(833,055)
BALANCE	-	-	-	

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

Fund Year allocation of claims have been estimated.

METROPOLITAN HEALTH INSURANCE FUND
YEAR: 2026

Monthly Items	Filing Status
Budget	**Filed**
Assessments	**Filed**
Actuarial Certification	**Filed**
Reinsurance Policies	**Filed**
Fund Commissioners	**Be Filed upon Re-organization**
Fund Officers	**Be Filed upon Re-organization**
Renewal Resolutions	**Be Filed upon Re-organization**
Indemnity and Trust	**Be Filed upon Re-organization**
New Members	**Filed as New Members are approved**
Withdrawals	**Filed as Members Withdrawal**
Risk Management Plan and By Laws	**Be Filed upon Re-organization**
Cash Management Plan	**Be Filed upon Re-organization**
Unaudited Financials	**Filed through Q3 2025**
Annual Audit	**2025 to be filed**
Budget Changes	**N/A**
Transfers	**N/A**
Additional Assessments	**N/A**
Professional Changes	**N/A**
Officer Changes	**N/A**
RMP Changes	**N/A**
Bylaw Amendments	**N/A**
Contracts	**Be Filed upon Re-organization**
Benefit Changes	**N/A**

Contract	Professional	Contract	Insurance	Term
Administration	PERMA	Y- in progress	Y	1/1/2024 - 12/31/2026*
Attorney	Antonelli Kantor Rivera	Y- in progress	Y	1/1/2024 - 12/31/2026*
Treasurer	Matt Laracy	Y- in progress	Y	1/1/2024 - 12/31/2026*
Deputy Treasurer	Derek Macchia	Y	Y	1/1/2024 - 12/31/2026*
Auditor	Bowman & Company	Y- in progress	Y	1/1/2025 - 12/31/2026*
Actuary	John Vataha	Y- in progress	Y	1/1/2024 - 12/31/2026*
Fund Coordinator	Eagle Rock	Y- in progress	Y	1/1/2024 - 12/31/2026*
QPA				
TPA - Aetna	Aetna	Y	Y	1/1/2026 - 12/31/2026
Medicare Advantage	Aetna	Y	Y	1/1/2026 - 12/31/2026
Medicare Advantage	UHC			
				*2 additional one-year terms - 2027 & 2028

METROPOLITAN HEALTH INSURANCE FUND
BILLS LIST

DECEMBER 2025

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Metropolitan Health Insurance Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2024

VendorName	Comment	InvoiceAmount
CAMERON COX	**VOID AND REISSUE**	-450.00
		-450.00
CAMERON COX	**VOID AND REISSUE**	-600.00
		-600.00
CAMERON COX	MEETING ATTENDANCE Q1 2024	450.00
CAMERON COX	Q4 24 & MAY MEETING ATTENDANCE 03/25	600.00
		1,050.00
	Total Payments FY 2024	**0.00**

FUND YEAR 2025

VendorName	Comment	InvoiceAmount
HQSI, INC	INV 251031-MRHIF-2 CASE# 4700362 10/25	900.00
		900.00
THE CANNING GROUP LLC	QPA METRO 2025-12	250.00
		250.00
SOUTHERN NEW JERSEY EBF	REIMB OSC REVIEW 12/25	2,499.93
		2,499.93
DEREK MACCHIA	DEPUTY TREASURER FEE 12/25	3,250.00
		3,250.00
TOWNSHIP OF WEST CALDWELL	2025 MEETING EXPENSE 12/25	1,200.00
		1,200.00
BLOOMFIELD LIBRARY	2025 MEETING EXPENSE 12/25	1,350.00
		1,350.00
TOWNSHIP OF BLOOMFIELD	2025 MEETING EXPENSE 12/25	1,200.00
		1,200.00
CAMERON E. COX	2025 MEETING EXPENSE 12/25	1,200.00
		1,200.00

CHRISTOPHER HARTWYK	2025 MEETING EXPENSE 12/25	750.00
		750.00
MARGARET HEISEY	2025 MEETING EXPENSE 12/25	1,350.00
		1,350.00
TOWNSHIP OF MAPLEWOOD	2025 MEETING EXPENSE 12/25	1,200.00
		1,200.00
GANNETT NEW YORK NJ LOCALIQ	A# 1488194 ORDER # 11757216 10/17/25	57.28
		57.28
NJ ADVANCE MEDIA	AD# 0011030608 9/24/25	16.91
		16.91
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 39648 11/25	6,119.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 39531 10/25	10,063.00
		16,182.00
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 12/25	58,088.02
		58,088.02
BROWN & BROWN METRO, LLC	BROKER FEES 12/25	14,653.22
		14,653.22
	CHECK TOTALS	**104,147.36**
AETNA	DECEMBER HOLIDAY CREDIT 12/25	-99,798.96
AETNA	MEDICAL TPA FEES 12/25	99,798.96
		0.00
AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 12/25	932,956.73
		932,956.73
UNITED HEALTHCARE INS COMPANY	MEDICARE ADVANTAGE 12/25	84,132.20
		84,132.20
DELTA DENTAL INSURANCE COMPANY	DENTAL- BE006836628 F1-7871900000 12/25	6,617.33
		6,617.33
FAIRVIEW INSURANCE AGENCY ASSOCIATES	BROKER FEES 12/25	34,953.57
		34,953.57
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 12/25	49,994.39
		49,994.39
EAGLE ROCK MANAGEMENT GROUP, LLC	FUND COORDINATOR 12/25	80,758.00
		80,758.00

DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 12/25	7,097.50
		7,097.50
INSURANCE SOLUTIONS, INC	BROKER FEES 12/25	610.00
		610.00
POINT ACCOUNTING GROUP	TREASURER FEES 12/25	2,250.00
		2,250.00
	ACH/WIRE TOTALS	**1,199,369.72**
	Total Payments FY 2025	**1,303,517.08**
	TOTAL PAYMENTS ALL FUND YEAR	**1,303,517.08**

_____
Chairperson

Attest:

_____

Dated:
_____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____
Treasurer

METROPOLITAN HEALTH INSURANCE FUND
BILLS LIST

JANUARY 2026

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Metropolitan Health Insurance Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2025

VendorName	Comment	InvoiceAmount
PERMA	POSTAGE 10/25	159.25
PERMA	POSTAGE	86.00
PERMA	POSTAGE 11/25	401.43
PERMA	POSTAGE 08/25	236.01
PERMA	POSTAGE 07/25	101.77
PERMA	PROGRAM MANAGER 02/25	42,265.85
PERMA	POSTAGE 12/25	586.24
PERMA	PROGRAM MANAGER 01/25	40,925.61
PERMA	ADMIN FEES 01/25	33,484.59
PERMA	POSTAGE 01/25	303.78
PERMA	POSTAGE 02/25	36.49
PERMA	ADMIN FEES 02/25	34,581.15
PERMA	POSTAGE 06/25	123.13
PERMA	POSTAGE 05/25	170.83
PERMA	POSTAGE 03/25	182.03
PERMA	POSTAGE 04/25	104.09
		153,748.25
SOUTHERN NEW JERSEY EBF	REIMB OSC REVIEW 12/25	213.27
		213.27
NJ ADVANCE MEDIA	AD# 0011039363 INV3564072 10/24/25	13.76
NJ ADVANCE MEDIA	AD# 0011037664 INV3564072 10/31/25	54.00
		67.76
ANTONELLI KANTOR RIVERA	ATTORNEY FEES - OSC REPORT 11/25	10,770.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES 11/3/25-11/20/25	3,345.00
ANTONELLI KANTOR RIVERA	OUT OF NETWORK BENE ISSUE 11/25	750.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES 10/1/25-10/29/25	5,250.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES - OSC REPORT 10/25	18,135.00
ANTONELLI KANTOR RIVERA	OUT OF NETWORK BENE ISSUE 10/25	270.00
		38,520.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 39766 12/25	7,743.00
		7,743.00
MUNICIPAL REINSURANCE H.I.F.	SPECIFIC REINSURANCE 01/25	207,481.22
		207,481.22
	CHECK TOTALS-2025	**407,773.50**
	Total Payments FY 2025	**407,773.50**

FUND YEAR 2026

VendorName	Comment	InvoiceAmount
PERMA	PROGRAM MANAGER FEES 01/26	44,972.51
PERMA	ADMIN FEES 01/26	36,795.69
		81,768.20
DEREK MACCHIA	DEPT. TREA. FEE W/ 25 OVERPAYMENT 01/26	500.00
		500.00
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 01/26	59,934.66
		59,934.66
CONNER STRONG & BUCKELEW	SURETY BOND 1/26-1/27	2,274.00
		2,274.00
BROWN & BROWN METRO, LLC	BROKER FEES 01/26	14,824.28
		14,824.28
MUNICIPAL REINSURANCE H.I.F.	SPECIFIC REINSURANCE 01/26	282,499.32
		282,499.32
	TOTAL CHECK-2026	**441,800.46**
AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 01/26	1,199,103.56
		1,199,103.56
UNITED HEALTHCARE INS COMPANY	MEDICARE ADVANTAGE 01/26	111,704.43
		111,704.43
DELTA DENTAL INSURANCE COMPANY	DENTAL- BE006867209 F1-78719000000 01/26	5,827.36
		5,827.36
FAIRVIEW INSURANCE AGENCY ASSOCIATES	BROKER FEES 01/26	35,714.71
		35,714.71
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 01/26	48,977.59
		48,977.59
EAGLE ROCK MANAGEMENT GROUP, LLC	FUND COORDINATOR 01/26	81,936.00
		81,936.00
DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 01/26	6,903.78
		6,903.78
AETNA	MEDICAL TPA FEES 01/26	84,892.50
		84,892.50
INSURANCE SOLUTIONS, INC	BROKER FEES 01/26	871.08
		871.08
POINT ACCOUNTING GROUP	TREASURER FEES 01/26	2,500.00
		2,500.00
	TOTAL ACH/WIRES	**1,578,431.01**
	Total Payments FY 2026	**2,020,231.47**
	TOTAL PAYMENTS ALL FUND YEARS	**2,428,004.97**

_____

Chairperson

Attest:

_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____

Treasurer

Metro Employee Benefits Fund

SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED

Current Fund Year: 2025 Month Ending: October	Medical	Dental	Rx	Vision	Run-In	Reinsurance	RSR	Admin	Dividend Reserve	BMED Interfund	TOTAL
OPEN BALANCE	(562,737.88)	159,602.71	(757,927.16)	0.00	0.00	2,075,764.07	875,205.01	1,329,394.27	0.00	0.00	3,119,301.02
RECEIPTS											
Assessments	5,199,608.48	103,033.27	188,291.83	0.00	0.00	172,821.73	54,246.15	374,704.07	0.00	0.00	6,092,705.53
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	10,005.18	198.70	0.00	0.00	0.00	2,584.28	1,089.61	1,663.39	0.00	0.00	15,541.16
Invest Adj	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal Invest	10,005.18	198.70	0.00	0.00	0.00	2,584.28	1,089.61	1,663.39	0.00	0.00	15,541.16
Other *	262,275.20	0.00	203,623.87	0.00	0.00	0.00	0.00	0.00	0.00	0.00	465,899.07
TOTAL	5,471,888.86	103,231.97	391,915.70	0.00	0.00	175,406.01	55,335.76	376,367.46	0.00	0.00	6,574,145.76
EXPENSES											
Claims Transfers	5,965,835.39	95,650.69	300,384.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6,361,870.31
Expenses	1,004,338.84	5,696.32	0.00	0.00	0.00	0.00	0.00	298,649.72	0.00	0.00	1,308,684.88
Other *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL	6,970,174.23	101,347.01	300,384.23	0.00	0.00	0.00	0.00	298,649.72	0.00	0.00	7,670,555.19
END BALANCE	**(2,061,023.25)**	**161,487.67**	**(666,395.69)**	**0.00**	**0.00**	**2,251,170.08**	**930,540.77**	**1,407,112.01**	**0.00**	**0.00**	**2,022,891.59**

CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES

Metro Employee Benefits Fund

Month	**October**
Current Fund Year	**2025**

Policy Year	Coverage	1. Calc. Net Paid Thru Last Month	2. Monthly Net Paid October	3. Monthly Recoveries October	4. Calc. Net Paid Thru October	5. TPA Net Paid Thru October	6. Variance To Be Reconciled	7. Delinquent Unreconciled Variance From	8. Change This Month
2025	Medical	44,631,025.52	5,633,663.07	0.00	50,264,688.59	0.00	50,264,688.59	44,631,025.52	5,633,663.07
	Dental	996,898.11	95,526.09	0.00	1,092,424.20	0.00	1,092,424.20	996,898.11	95,526.09
	Rx	3,088,079.67	300,389.23	0.00	3,388,468.90	0.00	3,388,468.90	3,088,079.67	300,389.23
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	**48,716,003.30**	**6,029,578.39**	**0.00**	**54,745,581.69**	**0.00**	**54,745,581.69**	**48,716,003.30**	**6,029,578.39**

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS			
Metro Employee Benefits Fund			
ALL FUND YEARS COMBINED			
CURRENT MONTH		**October**	
CURRENT FUND YEAR		**2025**	
		Description:	**CHECKING**
		ID Number:	
		Maturity (Yrs)	
		Purchase Yield:	
		TOTAL for All Accts & instruments	
Opening Cash & Investment Balance		**$3,119,301.01**	**3,119,301.01**
Opening Interest Accrual Balance		**$0.00**	**-**
1	Interest Accrued and/or Interest Cost	$0.00	$0.00
2	Interest Accrued - discounted Instr.s	$0.00	$0.00
3	(Amortization and/or Interest Cost)	$0.00	$0.00
4	Accretion	$0.00	$0.00
5	Interest Paid - Cash Instr.s	$15,541.14	$15,541.14
6	Interest Paid - Term Instr.s	$0.00	$0.00
7	Realized Gain (Loss)	$0.00	$0.00
8	Net Investment Income	$15,541.14	$15,541.14
9	Deposits - Purchases	$6,558,604.60	$6,558,604.60
10	(Withdrawals - Sales)	-$7,670,555.19	-$7,670,555.19
Ending Cash & Investment Balance		$2,022,891.56	$2,022,891.56
Ending Interest Accrual Balance		$0.00	$0.00
Plus Outstanding Checks		$1,612,453.43	$1,612,453.43
(Less Deposits in Transit)		$0.00	$0.00
Balance per Bank		$3,635,344.99	**$3,635,344.99**

METRO CLAIMS

Monthly Claim Activity Report

January 15, 2026

METRO

	MEDICAL CLAIMS PAID 2024	# OF EES	PER EE	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$724,016	2,682	**$ 270**	$4,688,076	2,369	**$ 1,979**
FEBRUARY	$3,974,566	2,658	**$ 1,495**	$4,919,355	2,436	**$ 2,019**
MARCH	$5,419,303	2,666	**$ 2,033**	$5,699,838	2,426	**$ 2,349**
APRIL	$6,007,197	2,624	**$ 2,289**	$7,407,692	2,431	**$ 3,047**
MAY	$4,346,049	2,630	**$ 1,652**	$7,222,409	2,434	**$ 2,967**
JUNE	$5,971,793	2,627	**$ 2,273**	$6,588,676	2,433	**$ 2,708**
JULY	$6,220,272	2,649	**$ 2,348**	$4,979,246	2,440	**$ 2,041**
AUGUST	$4,753,326	2,643	**$ 1,798**	$6,844,995	2,438	**$ 2,808**
SEPTEMBER	$4,750,184	2,627	**$ 1,808**	$6,588,652	2,405	**$ 2,740**
OCTOBER	$5,943,377	2,713	**$ 2,191**	$5,868,857	2,451	**$ 2,394**
NOVEMBER	$5,722,476	2,719	**$ 2,105**	$5,395,907	2,471	**$ 2,184**
DECEMBER	$6,521,762	2,118	**$ 3,079**			
TOTALS	**$60,354,319**			**$66,203,703**		
				2025 Average	**2,430**	**$ 2,476**
				2024 Average	**2,613**	**$ 1,945**

RUN OUT

	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$194,623	2,369	$ 82
FEBRUARY	$106,504	2,436	$ 44
MARCH	$67,081	2,426	$ 28
APRIL	$75,116	2,431	$ 31
MAY	$278,804	2,434	$ 115
JUNE	$40,812	2,433	$ 17
JULY	-$9,448	2,440	$ (4)
AUGUST	$5,435	2,438	$ 2
SEPTEMBER	$2,085	2,405	$ 1
OCTOBER	-$1,954	2,451	$ (1)
NOVEMBER	$18,483	2,471	$ 7
DECEMBER			
TOTALS	**$777,540**		

Large Claimant Report (Drilldown) - Claims Over $100000

Plan Sponsor Unique ID : All
Customer: **METRO**
Group / Control: 00232370,00232371 - METRO FUND

Paid Dates: 11/01/2025 - 11/30/2025
Service Dates: 01/01/2011 - 11/30/2025
Line of Business: All

	Paid Amt	Diagnosis/Treatment
	$187,340.47	BRACHIAL PLEXUS DISORDERS
	$169,942.94	ANEURYSM OF THE ASCENDING AORTA, WITHOUT RUPTURE
	$123,350.92	GASTROINTESTINAL HEMORRHAGE, UNSPECIFIED
	$120,768.99	SPONDYLOSIS WITHOUT MYELOPATHY OR
Total:	**$601,403.32**	

aetna™

Metropolitan Health Insurance Fund
12/1/24 thru 11/30/25 (unless otherwise noted)

Dashboard

Medical Claims Paid:
January 2025 thru November 2025

Total Medical Paid per EE: **$2,476**

** Claims Run-Out under old BMED control*

Network Discounts

Inpatient:	**64.8%**
Ambulatory:	**65.9%**
Physician/Other:	**64.2%**
TOTAL:	**64.9%**

Provider Network

% Admissions In-Network:	**94.4%**
% Physician Office:	**91.4%**

Aetna Book of Business:
Admissions 97.6%; Physician 91.8%

Top Facilities Utilized
(by total Medical Spend)

- JFK University Medical Center
- Overlook Medical Center
- Cooperman Barnabas Medical Ctr
- RWJUH New Brunswick
- Morristown Medical Center

Catastrophic Claim Impact
January 2025 – November 2025

Number of Claims Over $50,000: **219**
Claimants per 1000 members: **38.9**
Avg. Paid per Claimant: **$150,793**
Percent of Total Paid: **52.5%**

- **Aetna BOB- HCC account for an average of 46.1% of total Medical Cost**

Aetna One Flex Care Mgmt Member Outreach:

Total Members Identified: **1,529** (24.8%)
Members Targeted for 1:1 Nurse Support : **292** (**20.0%** engaged)
Members identified for Digital Activity: **1,237 (83.4%)**
Members receiving Aetna Advice: **414 (8.4%)**
Average Aetna Advice outreaches per member: **1.1**

CVS Health. CVS Virtual Care
January 2025 – November 2025

Completed Visits: **19**
Unique Patients : **16**
Completed Visits in 2025 : **179**
Unique Patients in 2025: **104**
Total Scheduled Visits in 2025: **240**
Average visit duration: **10** Minutes
BoB: Average First Available: **38** minutes
BoB: Average First Available (6am-6pm)
36 Minutes

Service Center Performance Goal Metrics YTD 2024

Customer Service Performance

1st Call Resolution:	**93.68%**
Abandonment Rate:	**0.46%**
Avg. Speed of Answer:	**12.6 sec**

Claims Performance

Financial Accuracy:	**97.76%***

*Q3 2025

-

90% processed w/in:	**7.4 days**
95% processed w/in:	**15.4 days**

****

Claims Performance (Monthly)
(November 2025)

90% processed w/in:	**6.6 days**
95% processed w/in:	**13.4 days**

(Note: This is not a PG metric)

****

Performance Goals

1st Call Resolution:	**90%**
Abandonment Rate less than:	**3.0%**
Average Speed of Answer:	**30 sec**
Financial Accuracy:	**99%**

Turnaround Time

90% processed w/in:	**14 days**
95% processed w/in:	**30 days**


EXPRESS SCRIPTS®

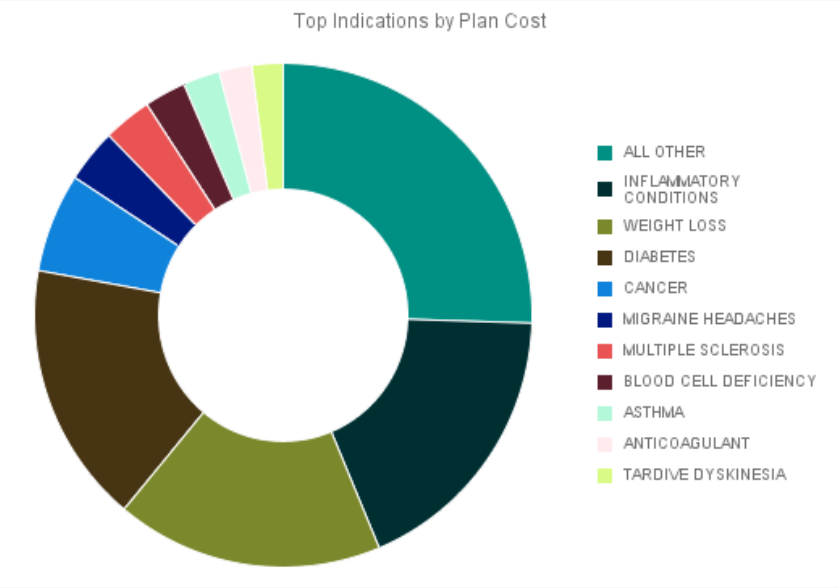
Metropolitan Health Insurance Fund

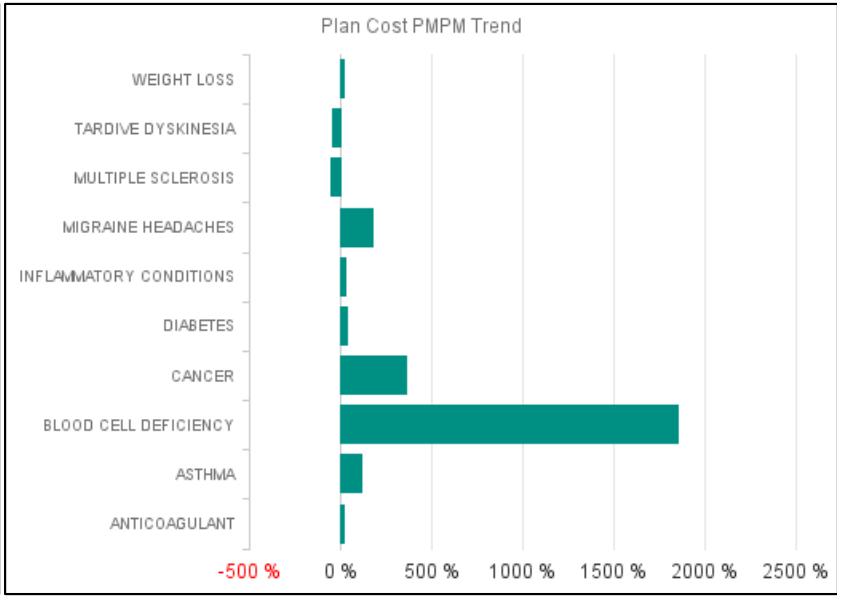
Total Component/Date of Service (Month)	2024 01	2024 02	2024 03	2024 Q1	2024 04	2024 05	2024 06	2024 Q2	2024 07	2024 08	2024 09	2024 Q3	2024 10	2024 11	2024 12	2024 Q4	2024 YTD
Membership	972	963	960	965	970	965	957	964	946	947	952	948	968	990	984	981	965
Total Days	24,314	27,528	27,455	79,297	29,053	32,052	27,820	88,925	30,797	29,467	30,030	90,294	34,030	32,808	35,417	102,255	360,771
Total Patients	284	292	308	465	318	308	301	485	303	307	315	469	357	353	362	539	715
Total Plan Cost	$153,801	$106,316	$117,731	$377,849	$138,031	$171,454	$156,213	$465,697	$205,353	$187,823	$167,234	$560,409	$274,108	$179,016	$214,628	$667,752	$2,071,708
Generic Fill Rate (GFR) - Total	86.2%	85.8%	86.1%	86.0%	86.5%	84.1%	84.0%	84.9%	83.7%	80.2%	80.4%	81.5%	81.2%	84.4%	81.9%	82.5%	83.6%
Plan Cost PMPM	$158.23	$110.40	$122.64	$130.52	$142.30	$177.67	$163.23	$161.03	$217.07	$198.33	$175.67	$196.98	$283.17	$180.82	$218.12	$226.97	$179.00
Total Specialty Plan Cost	$80,389	$23,717	$27,003	$131,108	$54,301	$37,700	$48,055	$140,057	$76,068	$71,220	$48,563	$195,851	$161,184	$53,548	$70,817	$285,549	$752,565
Specialty % of Total Specialty Plan Cost	52.3%	22.3%	22.9%	34.7%	39.3%	22.0%	30.8%	30.1%	37.0%	37.9%	29.0%	34.9%	58.8%	29.9%	33.0%	42.8%	36.3%

Total Component/Date of Service (Month)	2025 01	2025 02	2025 03	2025 Q1	2025 04	2025 05	2025 06	2025 Q2	2025 07	2025 08	2025 09	2025 Q3	2025 10	2025 11	2025 12	2025 Q4	2025 YTD
Membership	1,583	1,745	1,738	1,689	1,736	1,735	1,736	1,736	1,736	1,739	1,737	1,737	1,730	1,734			
Total Days	59,833	60,345	70,456	190,634	65,736	61,053	61,382	188,171	58,914	60,428	60,555	179,897	59,136	56,002			
Total Patients	550	598	602	927	596	543	555	895	540	544	557	866	568	549			
Total Plan Cost	$360,333	$263,585	$400,194	$1,024,112	$369,565	$337,451	$414,442	$1,121,458	$415,010	$369,278	$335,711	$1,119,999	$438,857	$345,729			
Generic Fill Rate (GFR) - Total	85.1%	84.0%	82.7%	83.9%	84.6%	84.0%	84.2%	84.3%	83.7%	83.5%	79.5%	82.2%	78.1%	81.7%			
Plan Cost PMPM	$227.63	$151.05	$230.26	$202.15	$212.88	$194.50	$238.73	$215.38	$239.06	$212.35	$193.27	$214.89	$253.67	$199.38			
% Change Plan Cost PMPM	43.9%	36.8%	87.8%	54.9%	49.6%	9.5%	46.3%	33.7%	10.1%	7.1%	10.0%	9.1%	-10.4%	10.3%			
Total Specialty Plan Cost	$144,724	$50,528	$138,310	$333,561	$144,054	$107,491	$196,191	$447,736	$165,644	$132,113	$111,477	$409,234	$197,300	$134,209			
Specialty % of Total Specialty Plan Cost	40.2%	19.2%	34.6%	32.6%	39.0%	31.9%	47.3%	39.9%	39.9%	35.8%	33.2%	36.5%	45.0%	38.8%			

Top Indications

Metropolitan Health Insurance (Current Period 01/2025 - 11/2025 vs. Previous Period 01/2024 - 11/2024) Peer = Government - National Preferred Formulary





			Current Period						Previous Period						Trend
Rank	Peer Rank	Indication	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Plan Cost PMPM
1	2	INFLAMMATORY CONDITIONS	24.4 %	290	$737,892	$38.94	55.2 %	29.1 %	24.7 %	121	$321,243	$30.33	49.6 %	32.6 %	28.4 %
2	4	WEIGHT LOSS	23.3 %	648	$703,086	$37.10	1.5 %	3.8 %	26.2 %	310	$340,488	$32.15	0.3 %	5.1 %	15.4 %
3	1	DIABETES	22.5 %	2,007	$681,419	$35.96	31.5 %	23.4 %	21.6 %	894	$280,915	$26.53	36.5 %	25.5 %	35.6 %
4	3	CANCER	8.5 %	72	$257,606	$13.59	83.3 %	75.5 %	2.4 %	41	$31,575	$2.98	97.6 %	75.8 %	356.0 %
5	5	MIGRAINE HEADACHES	4.6 %	196	$139,295	$7.35	35.2 %	51.0 %	2.1 %	49	$27,901	$2.63	57.1 %	52.6 %	179.0 %
6	7	MULTIPLE SCLEROSIS	4.2 %	19	$126,986	$6.70	47.4 %	47.0 %	10.8 %	23	$139,942	$13.21	47.8 %	48.2 %	-49.3 %
7	9	BLOOD CELL DEFICIENCY	3.6 %	12	$109,186	$5.76	50.0 %	16.1 %	0.2 %	1	$3,127	$0.30	0.0 %	0.7 %	1851.5 %
8	6	ASTHMA	3.3 %	867	$99,673	$5.26	85.7 %	88.0 %	2.0 %	426	$25,795	$2.44	89.0 %	88.0 %	115.9 %
9	8	ANTICOAGULANT	2.9 %	176	$86,521	$4.57	8.5 %	18.3 %	3.2 %	116	$41,848	$3.95	6.9 %	18.7 %	15.5 %
10	10	TARDIVE DYSKINESIA	2.7 %	12	$82,166	$4.34	0.0 %	6.5 %	6.6 %	13	$86,159	$8.14	0.0 %	6.7 %	-46.7 %
		Total Top 10		**4,299**	**$3,023,831**	**$159.58**	**39.7 %**	**38.3 %**		**1,994**	**$1,298,991**	**$122.66**	**42.8 %**	**41.4 %**	**30.1 %**

Top Drugs

Metropolitan Health Insurance (Current Period 01/2025 - 11/2025 vs. Previous Period 01/2024 - 11/2024) Peer = Government - National Preferred Formulary

					Current Period				Previous Period				Trend
Rank	Peer Rank	Brand Name	Indication	Specialty Drug	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Plan Cost PMPM
1	6	ZEPBOUND	WEIGHT LOSS	N	405	55	$412,763	$21.78	143	22	$140,771	$13.29	63.9 %
2	11	WEGOVY	WEIGHT LOSS	N	229	34	$289,029	$15.25	160	25	$198,838	$18.78	-18.8 %
3	199	SCEMBLIX	CANCER	Y	12	1	$257,217	$13.57	1	1	$15,777	$1.49	811.1 %
4	1	MOUNJARO	DIABETES	N	175	22	$177,368	$9.36	47	9	$46,265	$4.37	114.3 %
5	4	OZEMPIC	DIABETES	N	163	19	$148,642	$7.84	110	16	$95,901	$9.06	-13.4 %
6	26	SKYRIZI ON-BODY	INFLAMMATORY CONDITIONS	Y	14	2	$142,802	$7.54	10	1	$91,274	$8.62	-12.6 %
7	9	SKYRIZI PEN	INFLAMMATORY CONDITIONS	Y	16	2	$115,069	$6.07	4	1	$29,042	$2.74	121.4 %
8	10	JARDIANCE	DIABETES	N	170	21	$97,793	$5.16	56	8	$31,074	$2.93	75.9 %
9	129	VUMERITY	MULTIPLE SCLEROSIS	Y	10	1	$92,255	$4.87	12	1	$81,125	$7.66	-36.4 %
10	186	INGREZZA	TARDIVE DYSKINESIA	Y	12	1	$82,166	$4.34	13	1	$86,159	$8.14	-46.7 %
11	178	SOTYKTU	INFLAMMATORY CONDITIONS	Y	12	1	$74,501	$3.93	NA	NA	NA	NA	NA
12	176	ACTEMRA ACTPEN	INFLAMMATORY CONDITIONS	Y	13	1	$60,603	$3.20	14	1	$50,704	$4.79	-33.2 %
13	228	ELTROMBOPAG OLAMINE	BLOOD CELL DEFICIENCY	Y	6	1	$59,589	$3.14	NA	NA	NA	NA	NA
14	17	ENBREL SURECLICK	INFLAMMATORY CONDITIONS	Y	9	2	$58,475	$3.09	NA	NA	NA	NA	NA
15	274	HUMIRA(CF)	INFLAMMATORY CONDITIONS	Y	9	1	$52,954	$2.79	NA	NA	NA	NA	NA
16	20	ELIQUIS	ANTICOAGULANT	N	103	14	$51,873	$2.74	76	9	$25,208	$2.38	15.0 %
17	31	NURTEC ODT	MIGRAINE HEADACHES	N	33	9	$50,068	$2.64	10	3	$17,670	$1.67	58.4 %
18	137	PROMACTA	BLOOD CELL DEFICIENCY	Y	5	1	$48,957	$2.58	NA	NA	NA	NA	NA
19	24	FARXIGA	DIABETES	N	84	11	$44,492	$2.35	18	3	$9,148	$0.86	171.8 %
20	12	RINVOQ	INFLAMMATORY CONDITIONS	Y	4	1	$43,303	$2.29	NA	NA	NA	NA	NA
21	40	QULIPTA	MIGRAINE HEADACHES	N	40	5	$42,592	$2.25	5	2	$4,992	$0.47	376.9 %
22	32	TRULICITY	DIABETES	N	40	6	$37,088	$1.96	21	3	$19,121	$1.81	8.4 %
23	46	XOLAIR	ASTHMA	Y	15	2	$36,986	$1.95	NA	NA	NA	NA	NA
24	167	DIMETHYL FUMARATE	MULTIPLE SCLEROSIS	Y	9	1	$34,730	$1.83	11	1	$58,817	$5.55	-67.0 %
25	37	HUMIRA(CF) PEN	INFLAMMATORY CONDITIONS	Y	6	1	$33,999	$1.79	13	1	$74,665	$7.05	-74.6 %
			Total Top 25		**1,594**		**$2,545,315**	**$134.32**	**724**		**$1,076,549**	**$101.66**	**32.1 %**

METROPOLITAN HEALTH INSURANCE FUND
CONSENT AGENDA
JANUARY 15, 2026

The following Resolutions listed on the Consent Agenda will be enacted in one motion. Copies of all Resolutions are available to any person upon request. Any Commissioner wishing to remove any Resolution(s) to be voted upon, may do so at this time, and said Resolution(s) will be moved and voted separately.

RESOLUTION NO. 1-26

METROPOLITAN HEALTH INSURANCE FUND
APPOINTING PROFESSIONALS AND AWARDING CONTRACTS
FOR FUND YEAR 2026

WHEREAS, the Metropolitan Health Insurance Fund (the "Fund") is duly constituted as a Health Benefits Joint Insurance Fund pursuant to N.J.S.A. 40A:10-36 et seq**.**, and is subject to certain requirements of the Local Public Contracts Law, N.J.S.A. 40A:11-1 et seq**.**, and the Local Unit Pay-to-Play Law, N.J.S.A.19:44A-20.4 et. Seq.; and;

WHEREAS, the Fund found it necessary and appropriate to obtain certain professional services and other extraordinary and other unspecifiable services, as defined in the Local Public Contracts Law, (N.J.S.A. 40A:11-4.1et seq.) for the 2026 Fund year; and,

WHEREAS, the Fund duly advertised for public receipt of competitive contracts providing the required twenty (20) days prior to receipt for CC# 24-17 in a fair and open manner, consistent with Local Unit Pay-to-Play Law ., and

WHEREAS, the Fund received competitive contracts for professionals on December 17, 2025,

WHEREAS, the Fund recommends the award of contracts to the below listed Professional Service Providers and service organizations based on a review of their responses, experience, and prior service provided at the rates established by the Executive Committee; and

WHEREAS, the process was administered as required by law by the Qualified Purchasing Agent who has concurred with the legality of the purchase in accord with the New Jersey Local Public Contract Law (N.J.S.A. 40A:11-1 et seq.); and

WHEREAS, the term of each contract is three (3) years as authorized under N.J.S.A.40A:11-4.1 et. Seq.

WHEREAS, the Fund resolved to appoint the Professionals – noted below –commencing on January 1, 2025 and ending on December 31, 2027 at its January 2025 Reorganization Meeting in accordance with a fair and open process pursuant to N.J.S.A. 19:44A-20.4 et. seq. with the fees set for 2026 as outlined below;

NOW, THEREFORE, BE IT RESOLVED, by the Executive Committee of the Fund that the following professional service appointments and contract awards be and are hereby made for 2026:

I. **Actuarial Solutions LLC (John Vataha)** is hereby appointed to serve as the FUND's **Fund Actuary.** The annual amount of $18,207 has been appropriated in the **Actuary** Line Item of the 2026 budget.

II. **Bowman & Company is** hereby appointed to serve as the FUND's **Auditor** The annual amount of $22,889 for the 2026 Audit has been appropriated in the Audit Line Item of the 2026 budget.

III. **Antonelli Kantor Rivera PC** is hereby appointed to serve as the FUND's **Attorney.** The Fund Attorney will be paid $450/hourly for partners, $300/hourly for associate attorneys and $85/hourly for paralegals/clerks. The annual amount not exceeding $31,212 has been appropriated in the Attorney Line Item of the 2026 budget.

IV. **Point Accounting Group (Formerly Laracy Associates)** is hereby appointed to serve as the FUND's **Treasurer.** The annual amount of $30,000 has been appropriated in the Treasurer Line Item of the 2026 budget which is inclusive of the monthly retainer and an additional fee for new members.

V. **Derek Macchia** is hereby appointed to serve as the FUND's **Deputy Treasurer.** The annual amount of $7,500 has been appropriated in the Deputy Treasurer Line Item of the 2026 budget which is inclusive of the monthly retainer and an additional fee for new members; and

WHEREAS, the Fund recommended the award of contracts to the below firms and service organization based on a review of their; responses, experience and prior service provided at the rates established by the Executive Committee; and,

WHEREAS, the Fund resolved to appoint the extraordinary and other unspecifiable services contracts commencing on January 1, 2023 and ending on December 31, 2026 at its January 2025 Reorganization Meeting in accordance with a fair and open process pursuant to N.J.S.A. 19:44A-20.4 et. seq. with the fees set for 2026 as outlined below:

VI. **PERMA Risk Management Services** as **Administrator and Program Manager** is hereby appointed as **Executive Director, agent for process of service and Program Manager.** $20.40 per employee, per month, and $11.00 per Medicare Advantage employee, per month, and $6 per employee, per month for Dental will be expended to the Administrator. The estimated annual amount of $942,312 has been appropriated in the Administrator Line Item of the 2026 budget. In addition, $40,000 will be paid for special claim and operation audits upon completion.

VII. **Delta Dental** is hereby appointed to serve as the FUND's **Dental Claims Administrator.** $3.34 per medical employee, per month will be expended to the TPA. The estimated annual amount of $81,964 has been appropriated in the Dental TPA Line Item of the 2025 budget.

VIII. **Eagle Rock Management Group**, is hereby appointed to serve as the FUND's Fund Coordinator for the Metro subgroup lives only at $11 per Medicare Advantage life per

month; $20 per Active medical life per month; and $3 per dental only life, per month. The annual amount of $943,668 has been appropriated for this Line Item of the 2026 budget; and

WHEREAS, the Fund resolved to appoint the extraordinary and other unspecifiable services contracts commencing on January 1, 2025 and ending on December 31, 2027 at its January 2025 Reorganization Meeting in accordance with a fair and open process pursuant to N.J.S.A. 19:44A-20.4 et. Seq. with the fees set for 2026 as outlined below;

IX. **Aetna Medicare Advantage** is hereby appointed to serve as a Medicare Advantage service provider at the following per member, per month fee:

PlanName	Carrier	Renewal Premium
Aetna Medicare Advantage $10 w/ $6/$12/$24 Rx (North Hudson Regional Fire & Rescue)	AETNA - MAPDP	560.02
Aetna Medicare Advantage $10 w/ $6/$12/$24 Rx (Township of Chester)	AETNA - MAPDP	560.02
Aetna Medicare Advantage $10 w/ $6/$12/$24 Rx (Township of East Hanover)	AETNA - RXMAPDP	560.02
Aetna Medicare Advantage $10 w/$6/12/24 Rx (Union Township)	AETNA - MAPDP	560.02
Aetna Medicare Advantage $10 w/$6/$12/$24 Rx (Township of Millburn)	AETNA - RXMAPDP	560.02
Aetna Medicare Advantage PPO ESA (Township of Bloomfield)	AETNA - MAPDP	413.7
Aetna Medicare Advantage PPO ESA w $5/$5 Rx - MAPDP (Township of Irvington)	AETNA - MAPDP	638.64
Aetna Medicare Advantage PPO ESA w $9/$21/$41 Rx – MAPDP (Township of West Orange)	AETNA - MAPDP	697.16
Aetna Medicare Advantage PPO ESA w $9/$21/$41 Rx â€“ MAPDP (Township of West Orange)	AETNA - MAPDP	697.16
Aetna Medicare Advantage PPO ESA w/ Rx 10% (Town of Morristown)	AETNA - MAPDP	534.09
Medicare Advantage PPO ESA (City of Orange Township)	AETNA - MA	413.7

The annual amount of $12,914,226 has been appropriated for this Line Item of the 2026 budget.

X. **United Healthcare Medicare Advantage** is hereby appointed to serve as a Medicare Advantage service provider in the amount $492.09 per member, per month. The annual amount of $1,328,643 has been appropriated for this Line Item of the 2026 budget.

WHEREAS, at the November 10, 2025 Fund Executive Committee meeting, the Fund approved Resolution 28-25 awarding the appointment of Medical TPA via emergency procurement process commencing on January 1, 2026 and ending on December 31, 2026 in accordance with a fair and open process pursuant to N.J.S.A. 40A:11-6 et. Seq.;

XI. **Aetna** is hereby appointed to serve as the FUND's **Medical Claims Administrator.** $34.30 per employee, per month will be expended to the Administrator. The estimated annual

amount of $1,002,246 has been appropriated in the **Medical TPA** Line Item of the 2026 budget.

BE IT FURTHER RESOLVED that each of the above shall serve pursuant to a Professional Service Contract, which will be entered into and a copy of which will be on file in the Fund's office, located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054;

METROPOLITAN HEALTH INSURANCE FUND

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 2-26

METROPOLITAN HEALTH INSURANCE FUND
APPOINTING
PERMA RISK MANAGEMENT SERVICES
AS AGENT FOR THE FUND
FOR PROCESS OF SERVICE FOR THE YEAR 2026

WHEREAS, PERMA Risk Management Services, shall serve as Executive Director or Administrator and Program Manager, of the Metropolitan Health Insurance Fund, in accordance with Resolution No. 1-2026, and consistent with the definition prescribed of such position in N.JA.C. 11:15-3.2 and N.J.A.C. 11:15-5.2; and

NOW, THEREFORE, BE IT RESOLVED by the Executive Committee of the Metropolitan Health Insurance Fund, that PERMA Risk Management Services is hereby appointed as agent for process of service upon the Fund, at its office located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054, for the year 2026 or until its successor has been appointed and qualified.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 3-26

METROPOLITAN HEALTH INSURANCE FUND
DESIGNATING CUSTODIAN OF FUND RECORDS

BE IT RESOLVED that Patrick Wherry, the Secretary of the Metropolitan Health Insurance Fund is hereby designated as the custodian of the Fund records which shall be kept at the office of the Fund Administrator, located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 4-26

METROPOLITAN HEALTH INSURANCE FUND
DESIGNATING
THE STAR LEDGER AND THE RECORD
THE OFFICIAL NEWSPAPER FOR THE FUND YEAR 2026

WHEREAS, pursuant to P.L. 2025, c.72, effective March 1, 2026, public entities are required to publish all legal notices on their official websites, with a hyperlink to such notices prominently displayed on the homepage; and

WHEREAS, said law further requires public entities, for Fund Year 2026, to advertise at least twice per month in an eligible online news publication that legal notices may be viewed on the public entity's official website and to provide a hyperlink to the New Jersey Secretary of State's legal notice portal; and

WHEREAS, the Executive Committee of the Metropolitan Health Insurance Fund desires to designate official media for the advertising of legal notices in compliance with P.L. 2025, c.72;

NOW, THEREFORE, BE IT RESOLVED by the Executive Committee of the Metropolitan Health Insurance Fund that The Star-Ledger and The Record, each being an eligible online news publication, are hereby designated as the official media for the required twice-monthly advertisement of legal notices for Fund Year 2026; and

BE IT FURTHER RESOLVED that the official website of the Metropolitan Health Insurance Fund, located at www.metrohif.com, is hereby designated as the official electronic media site for the publication of all legal notices in accordance with applicable law.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 5-26

METROPOLITAN HEALTH INSURANCE FUND
FIXING PUBLIC MEETING DATES
FOR THE YEAR 2026

WHEREAS, under the Open Public Meetings Act of New Jersey, each public entity is required to publish the date and place for its public meetings;

NOW, THEREFORE, BE IT RESOLVED, by the Executive Committee of the Metropolitan Health Insurance Fund (the "Fund"), that the Fund hereby approves the following 2026 meeting dates, times and location for the Metropolitan Health Insurance Fund:

Date	Location	Time
February 19, 2026	Maplewood (In Person)	12:00pm
March 19, 2026	Virtual (Zoom)	12:00pm
April 16, 2026	Maplewood (In Person)	12:00pm
May 21, 2026	Virtual (Zoom)	12:00pm
June 18, 2026	Maplewood (In Person)	12:00pm
July 16, 2026	Virtual (Zoom)	12:00pm
August 20, 2026	Virtual (Zoom)	12:00pm
September 17, 2026	Virtual (Zoom)	12:00pm
October 15, 2026	Maplewood (In Person)	12:00pm
November 19, 2026	Virtual (Zoom)	12:00pm
December 17, 2026	Virtual (Zoom)	12:00pm

In Person Location:
The Woodland
60 Woodland Rd
Maplewood, NJ 07040

BE IT FURTHER RESOLVED, that the meetings will be conducted in a hybrid format and the public can find information about how to access the public meeting remotely at the following link: https://www.metrohif.com/

BE IT FURTHER RESOLVED, that the Secretary of the Fund is hereby directed to publish a copy of this Resolution in the Record and listed on the Fund Website (www.metrohif.com)

METROPOLITAN HEALTH INSURANCE FUND
ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

SECRETARY

RESOLUTION NO. 6-26

METROPOLITAN HEALTH INSURANCE FUND
DESIGNATING AUTHORIZED DEPOSITORIES FOR FUND ASSETS
AND ESTABLISHING CASH MANAGEMENT PLAN FOR 2026

BE IT RESOLVED, by the Executive Committee of the Metropolitan Health Insurance Fund, that the following Cash and Investment Management Plan be and is hereby adopted:

1.) **Cash Management and Investment Objectives**

The Metropolitan Health Insurance Fund (hereinafter referred to as the FUND) objectives in this area are:

a.) Preservation of capital.

b.) Adequate safekeeping of assets.

c.) Maintenance of liquidity to meet operating needs, claims settlements and dividends.

d.) Diversification of the FUND's portfolio to minimize risks associated with individual investments.

e.) Maximization of total return, consistent with risk levels specified herein.

f.) Investment of assets in accordance with State and Federal Laws and Regulations.

g.) Accurate and timely reporting of interest earnings, gains and losses by line of coverage in each Fund year.

2.) **Permissible Investments**

Investments shall be limited to investments authorized under N.J.S.A. 40A:5-15.1 Joint Insurance Funds and Chapter 38, Joint Insurance Funds, Subchapter 1. Investments 5:38-1.1, 5:38-1.2 and 5:38-1.3 of the New Jersey Administrative Code.

3.) **Authorized Depositories**

In addition to the above, the FUND is authorized to deposit funds in certificates of deposit and other time deposits in banks covered by the Governmental Unit Depository Protection Act, NJSA 17:9-14 et seq. (GUDPA). Specifically authorized depositories are as follows:

Citizens Bank
Kearny Bank

TD Bank
New Jersey Cash Management Fund
Bogota Savings Bank
Blue Foundry Bank
Four Leaf Credit Union

The FUND is also authorized to invest its assets in the New Jersey Cash Management Fund.

4.) **Authority for Investment Management**

The Treasurer is authorized and directed to manage the FUND's cash and investments in a manner consistent with this plan and all appropriate regulatory constraints.

5.) **Preservation of Capital**

Securities shall be purchased with the ability to hold until maturity.

6.) **Safekeeping**

Securities purchased on behalf of the FUND shall be delivered electronically or physically to the FUND's custodial bank, which shall maintain custodial and/or safekeeping accounts for such securities on behalf of the FUND.

7.) **Selection of Custodial and Operating Banks**

Custodial and operating banks shall be retained for contract periods of one (1) year. Additionally, the FUND shall maintain the ability to change asset managers and/or custodial banks more frequently based upon performance appraisals and upon reasonable notice, and based upon changes in policy or procedures.

8.) **Reporting**

The Treasurer shall report to the Executive Board at all regular meetings on all investments. This report shall include information on the balances in all bank and investment accounts, and purchases, sales, and redemptions occurring in the prior month.

9.) **Audit**

This plan, and all matters pertaining to the implementation of it, shall be subject to the FUND's annual audit.

10.) **Cash Flow Projections**

Asset maturity decisions shall be guided by cash flow factors prepared by the FUND's Actuary and reviewed by the Executive Director and the Treasurer.

11.) **Cash Management**

All moneys turned over to the Treasurer shall be deposited within forty-eight (48) hours.

In the event a check is made payable to the Treasurer rather than the Fund, the following procedure is to be followed:

b.) The Treasurer endorses the check to the Fund and deposits it into the Fund account.

b.) The Treasurer notifies the payer and requests that in the future any check be made payable to the Fund.

The Treasurer shall minimize the possibility of idle cash accumulating in accounts by assuring that all amounts in excess of negotiated compensating balances are kept in interest bearing accounts or promptly swept into the investment portfolio.

The method of calculating banking fees and compensating balances shall be documented to the Executive Board at least annually.

Cash may be withdrawn from investment pools under the discretion of asset managers only to fund operations, claims imprest accounts, or approved dividend payments.

The Treasurer shall escheat to the State of New Jersey checks which remain outstanding for twelve or more months after the date of issuance. However, prior to implementing such procedures, the Treasurer, with the assistance of the claims agent, as needed, shall confirm that the outstanding check continues to represent a valid claim against the FUND.

12.) **MEMBER MONTHLY BILLING POLICY**

To ensure timely billing and preservation of cashflow the Fund will follow this timeline and protocols as it relates to monthly invoices.

All enrollment changes must be entered into the system by the 15th of the month to reflect on the bill.

16th of the month – PERMA's Operations team will run and review all pre-bill audits.

Upon completion of the pre-bill audits – PERMA's Operations team will generate all invoices and associated billing reports. Review of adjustments are completed within two (2) business days of being generated

Bills are sent to accounting for review and approval, thereafter.

Upon receipt of accountings approval, invoices are sent to members within two business days

Bills are due the 15th of the billed month. Payments not received by the 15th are subject to a 10% interest penalty. The penalty will start accruing on the 1st of that billed month until the payment is received by the Fund Treasurer.

EXAMPLE: March 2026 bill for $100,000

Bill sent to member: February 15, 2026

Due Date: March 15, 2026

Member payment received: March 25, 2026.

Interest: March 1, 2026 – March 25, 2026: $27.40 per day = $657.53 total interest

Interest will be added as a line item adjustment on the next possible bill.

If any of the dates outlined above fall on a weekend or holiday, the due date will be the next business day.

If there is a delay on one member's bill, this will not hold up the distribution of any other of the Fund member bills.

All members should review their bills immediately and report any discrepancies so they can be addressed before the next invoice is generated.

The Fund's policy is to pay as billed and necessary adjustments will be reflected on a future invoice.

The member will receive a delinquent notice via email if payment is not made within a reasonable amount of time.

To assure timely payment of monthly assessments, the Fund shall implement a process of automatically initiating transfers from member entity bank accounts into the Fund accounts after detailed monthly assessment invoices are supplied to the member entities.

13.) MAXIMUM APPROVAL AMOUNT FOR CERTIFYING & APPROVING OFFICER

The FUND Treasurer shall act as "certifying and approval officer" and thus may issue checks or initiate wire transfers in payment of medical, pharmacy, and dental claims, as submitted by the third party administrator responsible for handling the FUND's claims, as necessary in order to fulfill the FUND's claim funding obligations under the applicable service provider contract between the FUND and the third party administrator. The certifying and approving officer shall prepare a report of all claims approved by him or her

in aggregate by year and line of coverage. This report shall be submitted to the Board of Trustees of the FUND at their next scheduled meeting. The Board of Trustees shall review and approve the actions of the certifying and approving officer

14.) DIRECT DEBIT

Members have the option to allow the Fund to collect monthly premiums through a direct debit to the Fund Operating Account initiated by the Fund Treasurer. The direct debit will equal the month's premium invoice and can be debited on the date of the member's choosing.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 7-26

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION DESIGNATING
AUTHORIZED SIGNATURES FOR FUND BANK ACCOUNTS

BE IT RESOLVED by the Metropolitan Health Insurance Fund that all funds of the Metropolitan Health Insurance Fund shall be withdrawn from the official named depositories, which shall bear the signatures of at least two (2) of the following persons who are duly authorized for the following bank accounts, pursuant to this Resolution.

Administrative Account:

Jenny Mundell	- Chairman
Patrick Wherry	- Secretary
Matthew Laracy	- Treasurer
Derek Macchia	- Deputy Treasurer

Claims Payment Account:

Jenny Mundell	- Chairman
Patrick Wherry	- Secretary
Matthew Laracy	- Treasurer
Derek Macchia	- Deputy Treasurer

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 8-26

METROPOLITAN HEALTH INSURANCE FUND

RISK MANAGEMENT PLAN

Effective: JANUARY 1, 2026

Adopted: JANUARY 15, 2026

METROPOLITAN HEALTH INSURANCE FUND
2026 RISK MANAGEMENT PLAN

BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2026 Fund year:

1.) COVERAGE OFFERED

- Medical

  The Fund offers a "point of services" and "open access" plan designs. These plans have both in network and out of network benefit. The Fund can offer other plans as may meet the needs of the members. Starting in 2012, the Fund also offered "low cost plans" to allow members options to comply with contribution requirements under Chapter 78 and for those covered under Chapter 44. Included as options are a health savings account-consumer directed health plan, a core PPO program, a buy up PPO program, an HMO plan and the plans for those covered under Chapter 44. The Fund also offers Medicare Advantage plans for Medicare eligible retirees.

- Dental

  The Fund offers customized dental plans as required by the members.

- Prescription

  The Fund offers customized prescription plans as required by the members, including plans that are coordinated with the low cost medical plan options. The Fund also offers "Employer Group Waiver Plans" for Medicare eligible retirees.

- Vision

  The Fund offers customized vision plans as required by the members.

2.) LIMITS OF COVERAGE

Limits of coverage vary by member plan design.

3.) RISK RETAINED BY THE FUND

The FUND provides coverage on a self-insured basis and secures excess insurance and/or reinsurance to cap the specific (i.e. per enrolled covered person per policy year) retention. The FUND is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The

MRHIF retains claims above the FUND's local specific retention and purchases an excess insurance policy and/or reinsurance that is filed with the New Jersey Department of Banking and Insurance in accordance with the applicable regulations.

The Fund takes no risk on Medicare Advantage and Employer Group Waiver Plan fully-insured policies purchased for Medicare retirees.

Pre-Medicare retirees and active employees and their dependents are covered by self-insured plans. Risk retained by the Fund for these plans is summarized as follows:

Medical and Prescription:

- **Specific Coverage:** The Fund self-insures for the first $425,000 per person per agreement year and obtains reinsurance through its membership in the Municipal Reinsurance Health Insurance Fund "MRHIF" for claims in excess of its Self-Insured Retention "SIR" to an unlimited maximum per person per contract period (incurred in 12 months paid in 24 months).
- **Specific Limit:** Unlimited
- **Basis**: Incurred 12 months, paid 24 months.

- **Aggregate Coverage:** The Fund does not purchase aggregate coverage given its surplus position and as a result of long term cost-benefit analysis of the effectiveness of such coverage for joint insurance funds in New Jersey.

- **Dental Specific and Aggregate Claims Coverage:** The FUND does not purchase either aggregate or specific coverage for dental claims.

Extra contractual claims are excluded from reinsurance coverage.

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The Fund complies with statutory accounting standards and establishes reserves on the probable total claim costs at conclusion. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted based on earned underwriting income and the number of months since the inception of the Fund year. This accrual is the adjusted at the end of each quarter in accordance with the actuary's projections.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the year, the Fund adopts a budget for the upcoming year based on the most recent census. Per employee rates are computed for each line of coverage for

each Fund member, and are approved by the Fund as a part of the budget adoption and rate certification process. These rates are used to compute the members' monthly assessment based on the updated census, and are mailed to the members approximately 15 days before the beginning of the month. The billing also includes the member's updated census for verification each month by the local entity. Retroactive adjustments for enrollment changes are limited to 2 months. Former participants (COBRA, Conversion and some retirees) and, in some cases, Dependents under age 31, are billed directly by the Fund. Should there be a need to enroll or terminate an employee past sixty (60) days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the fiscal impact on the Fund. The Committee will approve/deny the request within Forty-five (45) days.

6.) COVERAGE PURCHASED FROM INSURERS AND PARTICIPATION IN THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND (MRHIF)

The Fund provides coverage on a self-insured basis, and secures excess insurance to cap the Funds' specific (i.e. per covered person per policy year) retention. The Fund is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The MRHIF retains claims above the Fund's local specific retention and purchases an excess insurance policy that is filed with the Department of Banking and Insurance in accordance with the applicable regulations.

7.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, the prospective member's benefit program is reviewed by the actuary to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

a.) age/sex factor as compared to the average for the existing Fund membership;
b.) the plan of benefits for the prospective member; and
c.) loss data if available.

The actuary then recommends a relativity factor and estimated assessment for the entity. This recommendation requires Fund approval before the prospective member is admitted to the Fund.

Rates for all members are adjusted at the beginning of each Fund year to reflect the new budget. The Fund may also adopt mid Fund year rate changes to reflect changes in plan design, participation in lines of coverage, or a budget amendment. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the remaining lines of coverage may be adjusted and the entity shall not be eligible for membership in the dropped line of coverage for a three year period.

Unless otherwise authorized as part of the offer of membership, when a member joins during a FUND year, the member's initial rates are only valid through the end of the then current FUND year at which time the rates are adjusted for all members to reflect the new budget.

Prospective members may be offered entry rates of up to eighteen (18) months to allow for the alignment of renewals with the fiscal years of the FUND or of the entity.

Loss experience used by the Fund to determine loss ratio adjustments will be made available twice per year to members at no additional cost. For entities with loss ratios of 100% or greater, rate adjustments of up to +2.5% may be considered. For entities with loss ratios below 100%, rate adjustments of up to -2.5% may be considered. Additional adjustments can be considered for plans lacking standard utilization management features.

"Loss experience data" is defined as monthly claims and assessments for a three year period including de-identified specific claims at 50% of the Fund's self-insured retention. Requests for additional claims data can be considered based upon the availability of data, the feasibility of extracting the data, and the reimbursement to the Fund or its vendors of data extraction and formatting costs.

8.) RATING PERIODS

All rating periods for municipal members coincide with the Fund year while rating periods for school members can coincide with their fiscal year (July 1 to June 30).

9.) FACTORS IF RATES FOR MEMBERS JOINING THE FUND DURING A FUND YEAR ARE TO BE ADJUSTED.

Unless otherwise authorized as part of the offer of membership, where a member joins during a Fund year, the member's initial rates are only valid through the end of that Fund year or, for schools, fiscal year, at which time the rates are adjusted for all members to reflect the new budget.

10.) PROVISION FOR PPOs, etc.

The Fund offers employees the option of selecting various plans depending upon member bargaining agreements. Generally, it is the policy of the Fund to encourage selection of lower cost plan designs as opposed to traditional indemnity plans, and the Fund provides promotional material to assist members in employee communication programs concerning optional plan designs.

11.) OPEN ENROLLMENT PROCEDURES

Open enrollment periods shall be scheduled by the Fund at least yearly for each member and as is otherwise required to comply with plan document requirements and to effectuate plan design, network changes, and plan migrations that may take place.

12.) COBRA AND CONVERSION OPTIONS

The Fund provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The Fund has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. Where provided for in a member's plan document, the Fund provides a conversion option at rates established by the Fund. Unless otherwise specified in the member's plan document, the conversion option duplicates the conversion option offered by the SHBC. The Fund's coverage for individuals covered under COBRA or conversion options shall terminate effective the date the member withdraws from the Fund, or otherwise ceases to be a member of the Fund.

13.) DISCLOSURE OF BENEFIT LIMITS

The Fund discloses benefit limits in plan booklets provided to all covered employees.

14.) PARTICIPATION RULES WHEN ALL OR PART OF THE PREMIUM IS DERIVED FROM EMPLOYEE CONTRIBUTIONS

All assessments, including additional assessments and dividends, are the responsibility of the member, not the employee or former employee. Employee contributions, if any, are solely an internal policy of the member which shall not impact on the member's obligations to the Fund or confer any additional rights to the employees. Where the Fund directly bills an employee, (i.e. COBRA, etc.), this shall be considered as a service to reduce the member's administrative burden, and the member shall be responsible in the event of non-payment.

15.) RETIREES

The Fund duplicates coverage for eligible retirees. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund, or otherwise ceases to be a member of the Fund.

16.) NEWBORN CHILDREN

All plan documents will have the following language:
"You may remove family members from the policy at any time, but you may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is your responsibility to notify your employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until you have formally requested that change. Newborn children, but not grandchildren of an eligible employee, shall be automatically covered from birth for sixty (60) days, even if not enrolled within the required sixty (60) days. In the event of an eligible dependent giving birth to a child, (a grandchild) benefits for any hospital length of stay in connection with childbirth for the mother or newborn grandchild will apply for up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn grandchild's attending provider, after consulting with the mother, may discharge the mother or her newborn grandchild earlier than 48 hours (or 96 hours as applicable). Pursuant to

N.J.A.C. 11:15-3.6 (d) 17, automatic coverage of a newborn child or an adopted child is provided for a period of 60 days from the date of birth or the date of adoption."

17.) PLAN DOCUMENT

The Fund prepares a detailed plan document for each member local unit (or each employee bargaining group within a member local unit as the case may be), and an employee handbook provides a summary of the coverage provided by the plan. Each booklet (or certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

A.) General Information

- Enrollment procedures and eligibility.
- Dependent eligibility.
- When coverage begins.
- When can coverage be changed.
- When does coverage end.
- COBRA provisions.
- Conversion privilege
- Enrollment forms and instructions.

B.) Benefits

- Definitions.
- Description of benefits.
- Eligible services and supplies.
- Deductibles and co-payments.
- Examples as needed.
- Exclusions.
- Retiree coverage, before age 65 or after (if any)

C.) Claims Procedures

- Submission of claim.
- Proof of loss.
- Appeal procedures. Shall be in accordance with applicable governing law. See also Plan Document and FUND Risk Management Plan and Bylaws

D.) Cost Containment Programs

- Pre-admission.
- Second surgical opinion.

- Case Management
- Other cost containment programs
- Application and level of employee penalties.

18.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately every six months after the end of a Fund year, the Fund evaluates the results to determine if dividends or additional assessments are warranted. Most claims are paid within twelve months of year end, and at that time the Fund begins to consider closing the year, unless excess insurance recoveries are pending or litigation is likely.

Fully insured plans are not considered in surplus retention. Entities with only Medicare Advantage/Employer Group Waiver Programs are not included in closed year balance shares.

When the Fund determines that a Fund year should be closed:

- A reserve is established by the actuary to cover any unpaid claims or IBNR
- The Fund decides on the final dividend or supplemental assessment.
- A closure resolution is adopted transferring all remaining assets and liabilities of that Fund year to the "Closed Fund Year/Contingency Account".
- Each member's pro rata share of the residual assets are computed and added to its existing balance in the Closed fund Year/Contingency Account. Any member who has withdrawn from the Fund shall receive its remaining share of the Closed fund Year/Contingency Account six years after the date of its withdrawal.

19.) "RUN-IN" or "RUN-OUT" LIABILITY

The Fund covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former Fund member during the period it was a member. Upon approval of the Executive Committee, the Fund may also cover the run-in liability of a perspective member (i.e., the liability for claims incurred but not reported by a prospective member in connection with the provision of health benefits during the period prior to joining the Fund). When the Fund covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the Fund's actuary and approved by the Executive Committee. The assessment shall be paid entirely within the Fund year the member joined the Fund.

20.) CLAIMS, OPERATIONS AND ENROLLMENT AUDITS

The Fund retains a claim auditor experienced in auditing self-insured claims and operations. Claims and/or operational audits will be performed after the first year of operation and at least every three (3) years thereafter.

The FUND may require enrollment audits for new and existing members to ensure that benefits are paid only for persons meeting eligibility requirements.

21.) CLAIM APPEALS

- The third party administrator (TPA) shall initially review all appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

- The TPA shall provide the Executive Director and the Fund Attorney with a copy of the memo, which has been prepared concerning the appeal.

- The TPA, Executive Director and Fund Attorney shall confer concerning the merits of an appeal and they shall render a decision concerning the appeal provided that the appeal is

    - (a) In an amount not greater than $5,000.00 and/or

    - (b) Has been reviewed and recommended for approval by an independent, third party medical review consultant.

- If the decision of the TPA, Executive Director and Fund Attorney is to pay the claim, then the TPA is hereby authorized to issue the necessary check in payment of the claim.

- The Executive Committee of the Fund shall formally confirm the decision of the TPA, Executive Director and Fund Attorney to pay the claim and ratify the payment issued pursuant to that decision at the next meeting of the Executive Committee.

    - If the decision of the TPA, Executive Director and Fund Attorney is to deny the claim, the appeal shall be subject to the "adverse benefit determination" appeal process that is required pursuant to applicable law. The plan participant (hereinafter sometimes referred to as "claimant") shall at that time be advised that the adverse benefit determination may be appealed to the Fund's Independent Review Organization ("IRO"). The claimant's identity shall be revealed only upon the written request of the claimant. A copy of such written request with respect to disclosure of the claimant's name shall be sent to the Executive Director.

a. An appeal of an adverse benefit determination must be filed by the claimant within four (4) months from the date of receipt of the notice of the adverse benefit determination. The claimant shall submit a written request to the Executive Director to appeal an adverse benefit determination and/or final internal adverse benefit determination made by the TPA and the written request, shall be accompanied by a copy of the determination letter issued by the TPA.

1. The Executive Director will conduct a preliminary review within five (5) business days of the receipt of the request for an external review. There is no right to an external review by the IRO if (i) the claimant is or was not eligible for coverage at the time in question or (ii) the adverse benefit determination or final internal adverse benefit determination is based upon the failure of the claimant or covered person to met requirements for eligibility under the Plan or (iii) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit. The Executive Director shall notify the claimant if (a) the request is not eligible for external review; (b) that additional information is needed to make the request complete and what is needed to complete the request; or (c) the request is complete and is being forwarded to the IRO.

2. The Executive Director shall then forward an eligible, complete request for external review to the IRO designated by the Fund who shall be required to conduct its review in an impartial, independent and unbiased manner and in accordance with applicable law.

3. The assigned IRO will provide timely written notice to the claimant of the receipt and acceptance for external review of the claimant's request and shall include a statement that the claimant may submit, in writing and within ten (10) business days of the receipt of the notice, additional information which shall be considered by the IRO when conducting the external review. Upon receipt of any information submitted by the claimant, the IRO, within one (1) business day, shall forward the information to the Program Manager who may reconsider the adverse benefit determination or final internal adverse benefit determination and, as a result of such reconsideration, modify the adverse benefit determination or final internal adverse benefit determination. The Program Manager shall provide prompt written notice of any such modification to the claimant and the IRO.

4. The Executive Director, within five (5) business days of the assignment of the IRO, shall deliver to the IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. The IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination if the Executive Director does not provide such information in a timely manner. In such event, the IRO shall notify the claimant and the Program Manager of the decision within one (1) business day.

5. The IRO shall complete the external review and provide written notice of its final external review decision within forty-five (45) days of receipt of the request for the external review. In the case of a request for expedited external review of an adverse benefit determination or final internal adverse benefit determination where delay would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, the IRO shall provide notice of the final external review decision as expeditiously as possible but in no event more than 72 hours after the receipt of the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Program Manager within 48 hours of providing that notice in the case of an expedited external review. The IRO shall deliver notice of its final external review decision to both the claimant and the Executive Director for all external reviews conducted. The notice of decision shall contain:

(i) a general description of reason for the external review with sufficient information to identify the claim, claim amount, diagnosis and treatment codes and reason for previous denial;

(ii) the date the IRO was assigned and date of the IRO's decision;

(iii) references to the documentation/information considered;

(iv) a discussion of the rationale for the IRO's decision and any evidence-based standards relied upon in making the decision;

(v) a statement that the decision is binding on the claimant and the Fund subject to the claimant's right to seek judicial review of the same; and

(vi) that the claimant may contract the New Jersey health insurance consumer assistance office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625, phone (800) 446-7467 or (888) 393-1062 (appeals) website: http://wwww.state.nj.us/dobi/consumer.htm e-mail: ombudsman@dobi.state.nj.us/

22.) ENROLLMENTS AND TERMINATIONS PAST 60 DAYS

Enrollments and terminations can be processed up to 60 days in the past. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the financial impact to the Fund. The Committee will approve/deny the request within 45 days.

23.) PARTIAL MONTH ENROLLMENTS

When processing enrollments and terminations, the Fund will charge a member for a full month rate for an employee that is enrolled between the 1st and the 15th of the month but will charge the member in the following month if an enrollment occurred between the 16th and the 31st of the month. If a member should term between the 1st and the 15th of the month, the Fund will not

charge the member a rate for the enrollment but will charge a full month rate if a member terms between the 16th and the 31st of the month.

24.) **MEDICARE ADVANTAGE/EGWP ONLY**

The Fund may offer retiree coverage with a fully insured Medicare Advantage and/or Employer Group Waiver Program membership to an entity that does not have its active members in the Fund. The carrier will provide the Fund with a per employee, per month cost for a plan that matches equal to, or better to the current retiree plan. The Fund may add additional expenses to the price per employee. The entity would be required to sign an Indemnity and Trust agreement.

25.) **DIRECT DEBIT**

Members have the option to allow the Fund to collect monthly premium through a direct debit to the Fund Operating Account initiated by the Fund Treasurer. The direct debit will equal the month's premium invoice and can be debited on the date of the member's choosing.

26). **OUT OF NETWORK MEDICARE SCHEDULE APPEAL PROCESS**

Once the member appeal has been submitted, the Executive Director's Office shall initially review all OON payment appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

An Out of Network benefit appeal must be filed by the claimant within thirty (30) days from the date of receipt of the Explanation of Benefits (EOB) reflecting the 175/150% of Medicare

The Executive Director will conduct a preliminary review within five (5) business days of receipt of the request for a Third-party review and notify the member and/or representing broker, the request is being forwarded to a Third-Party Review Organization, who shall be solely responsible for reviewing Out of Network claims reimbursement.

The Executive Director shall then forward an eligible, complete request for external review to the Out of Network Third Party Review Organization.

The Third-Party Review Organization designated by the FUND will be required to conduct its review in an impartial, independent, and unbiased manner and in accordance with applicable law within thirty (30) business days after receipt.

If the decision of the Third-Party Review Organization responsible for the final determination is to pay the additional reimbursement at a level above the FUND approved 175%/150%

Medicare, then the TPA is hereby authorized to issue the adjusted payment to the provider.

If the decision of the Third-Party Review Organization responsible for the final determination is to NOT pay the additional reimbursement in excess of the FUND approved 175%/150% of Medicare, then the Program Manager will notify the member and/or representing broker within five (5) business days.

Regardless of the determination, the Third-Party Review Organization will provide on their letterhead the reason for the determination in addition to any specific data and metrics supporting that determination.

27.) QUALITY AND CLINICAL PLAN MANAGEMENT

The FUND shall have right to review, evaluate, and then implement certain Quality and Clinical Management programs related to the Medical, Pharmacy and Dental plans, as may be warranted from time to time, to address new and emerging issues related to the effective administration of the FUND. None of the programs shall constitute a change in benefit and shall not increase participant cost sharing. These programs may include and are not limited to Pharmacy and Medical quality and utilization programs that require a plan member to participate in a program intended to manage quality and improve outcome. If adopted by the FUND, such programs shall apply to all members of the FUND. The FUND shall utilize a formulary of preferred medications. The formulary will change from time to time as managed by the FUND's contracted Pharmacy Benefit Manager. Any changes to the formulary impacting a plan member will be addressed through advance notice to plan members. There will always be alternative medications available in each therapeutic class.

- Drug Utilization Management – The FUND may adopt or amend drug utilization management programs intended to impact the appropriate use of medications. These may include and are not limited to step therapy, generics preferred, formulary, retail network, prior authorization, and other programs provided for by the FUND's contracted Pharmacy Benefit Manager.

- Medical Care Management – The FUND may adopt or amend medical management plans intended to ensure member safety and efficacy of the health care program. This may include and not be limited to programs provided by the FUND's contracted Third-Party Administrator or others that can administer such programs.

- Out of Network Fee Schedules - The FUND shall adopt and amend the out of network fee schedule ("the schedule") used from time to time. The schedule shall be based on an independent methodology, generally Medicare plus a markup (i.e., 150% of Medicare) that ensures fairness and reasonableness related to the provider type, type of procedure and geography. If adopted by the FUND such programs shall apply to all members of the FUND. Individual members may separately be exempted from the application of such programs only with the express approval of the TRUSTEES and after agreeing to an

appropriate rate adjustment.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 9-26

METROPOLITAN HEALTH INSURANCE FUND
APPOINTING OF FUND COMMISSIONER, AND ALTERNATE FUND COMMISSIONER TO THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND

WHEREAS, the Metropolitan Health Insurance Fund has agreed to join the Municipal Reinsurance Health Insurance Fund; and

WHEREAS, by virtue of the conditions of membership contained in the by-laws of the fund, the Metropolitan Health Insurance Fund must appoint a Fund Commissioner and an Alternate Fund Commissioner;

NOW, THEREFORE, BE IT RESOLVED, by Executive Committee of the Metropolitan Health Insurance Fund, that the appointments be as follows:

1. That _____ is hereby appointed as Fund Commissioner.

2. That _____ is hereby appointed as Alternate Fund Commissioner.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 10-26

METROPOLITAN HEALTH INSURANCE FUND
ESTABLISHING PLAN FOR COMPENSATING PRODUCERS LICENSED PURSUANT TO N.J.S.A. 17:22A-1 ET SEQ AND REPRESENTING MEMBER ENTITIES

WHEREAS, The Metropolitan Health Insurance Fund permits member entities that designate a producer or risk manager to represent them in dealings with the Fund; and

WHEREAS, Pursuant to N.J.A.C. 11:15-3.6 (e) 15, producer arrangements must be formally determined by the Fund and filed with the Department of Banking and Insurance; and

NOW THEREFORE BE IT RESOLVED, that the Metropolitan Health Insurance Fund establishes the following producer plan for 2026;

1. The Fund will include producer compensation in each entity's assessments using the compensation levels as disclosed to and approved by the member entity.
2. The following sub-producers with the designated compensation levels are approved for 2026:

Group Name	RMC Name	RMC Rate	RMC Rate Dental
Bloomfield Township	IMAC	$ 65.22	$ -
Bloomfield Library	IMAC	$ 65.22	$ -
Chester Township	Brown & Brown Metro	$ 60.80	$ -
East Amwell	Insurance Solutions	$ 124.44	$ -
East Hanover	IMAC	$ 89.62	$ -
Irvington	Fairview Insurance	$ 7.97	$ -
Maplewood	Brown & Brown Metro	$ 60.36	$ -
Town of Morristown	Fairview Insurance	$ 21.65	$ -
Orange Township	Fairview Insurance	$ 56.44	$ 1.39
Plainfield BOE	Reliance Insurance Group	$ 28.45	$ -
Scotch Plains Township	Reliance Insurance Group	$ 59.17	$ -
Union Township	Fairview Insurance	$ 10.61	$ -
West Caldwell	IMAC	$ 46.83	$ -
West Orange Township	Fairview Insurance	$ 53.00	$ -

3.This schedule may be amended upon written notification of each listed member entity.

METROPOLITAN HEALTH INSURANCE FUND

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST: _____
SECRETARY

RESOLUTION NO. 11-26

METROPOLITAN HEALTH INSURANCE FUND
AUTHORIZING COMMISSION TREASURER TO PROCESS
CONTRACTED PAYMENTS AND EXPENSES

WHEREAS, the Executive Committee has deemed it necessary and appropriate to provide authorization to the Fund Treasurer to pay certain Fund contracted payments and expenses during the month(s) when the Commission does not meet; and

WHEREAS, payment by the Fund Treasurer of contracted payments and expenses for the month(s) in which the Fund does not meet shall be ratified by the Fund at its next regularly scheduled meeting; now, therefore,

BE IT RESOLVED by the Executive Committee of the Metropolitan Health Insurance Fund that the Fund Treasurer is hereby authorized to process the contracted payments and Fund expenses for all months in which the Fund does not meet during the year 2026.

BE IT FURTHER RESOLVED that the Executive Committee of the Metropolitan Health Insurance Fund shall ratify the contracted payments and Fund expenses so paid by the Fund Treasurer pursuant to the Resolution at its next regularly scheduled monthly meeting.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 12-26

METROPOLITAN HEALTH INSURANCE FUND
CORRECTIVE RESOLUTION
RENAMING RESOLUTION NO. 27-25 TO RESOLUTION NO. 31-25

WHEREAS, the Metropolitan Health Insurance Fund (the "Fund") adopted Resolution No. 27-25 on November 10, 2025, titled "*Adoption of the 2026 Proposed Budget*"; and

WHEREAS, it was subsequently determined that Resolution No. 27-25 was inadvertently assigned in error, as that number had already been used, resulting in a duplicate numbering conflict; and

WHEREAS, the Fund desires to correct this clerical error to ensure the accuracy and integrity of the official records;

NOW, THEREFORE, BE IT RESOLVED, by the Executive Committee of the Metropolitan Health Insurance Fund that Resolution No. 27-25, adopted November 10, 2025, is hereby renumbered and shall be officially recorded as Resolution No. 31-25; and

BE IT FURTHER RESOLVED that this correction is administrative in nature and does not amend, modify, or alter the action taken in the original resolution, which remains unchanged and in full force and effect; and

BE IT FURTHER RESOLVED that the Secretary is directed to update all official records, including the prior meeting's minutes, to reflect this correction.

ADOPTED: January 15, 2026

BY:_____

CHAIRPERSON

ATTEST:

_____

SECRETARY

RESOLUTION NO. 13-26

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION ESTABLISHING SUPPLEMENTAL ASSESSMENTS FOR THE 2024 FUND YEAR

WHEREAS, supplemental assessments are needed to assure the timely and complete payment of claims that have resulted from the higher than budgeted claims expenses; and

WHEREAS, a hearing on this supplemental assessment will be held at the Fund's regularly scheduled and advertised meeting of February 19, 2026 at The Woodland – 60 Woodland Road, Maplewood NJ 07040 at 12:00PM.

NOW, THEREFORE, BE IT RESOLVED that the following supplemental assessment and financial plan be and is hereby introduced:

1. Supplemental assessments for the 2024 and closed fund years for the Fund be and are hereby declared in an amount of $7,000,000 to reduce projected deficiencies in the claims account.

2. The allocation of supplemental assessments by member shall be pro rata as contained in Appendix 1 and is based upon proportional and cumulative assessments by member for the years with the deficits.

3. Member entities with balances in the Closed Year Account are authorized to apply those balances against the supplemental assessment.

4. This supplemental assessment may be amended depending upon maturation of claims incurred in 2024 and the closed years and paid in subsequent periods, reinsurance recoveries, and the financial need of the Fund. Amendments to this supplemental assessment may occur after completion of the public hearing, after close out of the 2024 fund year, or upon material reappraisal of the status of the 2024 fund year and closed years by the Fund. All amendments shall be made with appropriate notice to Fund members and opportunity for a public hearing.

5. Supplemental assessments shall be due and payable in accordance with the following provisions:

    a. For entities (if any) that terminate membership in the Fund or terminate coverage in the medical line of coverage prior to full payment of their supplemental assessment: The remaining unpaid balance of the supplemental assessment and the unpaid balance, if any, in the Closed Year Account and in any open Fund Years, shall be paid, either upon termination or over a period not to exceed three years starting with the first month of the date of termination of membership or medical coverage. In order to qualify to pay the supplemental assessment over two years, the entity shall adopt a resolution agreeing to pay the unpaid balance, along with any administrative or

interest charges, by resolution. The resolution shall be the form approved by the Fund. Failure to pay the balance or any term payments in full shall cause the Fund to assess a late payment interest charge and to withhold payment of claims.

The Supplemental Assessment collection will be used to pay outstanding fees and premiums, including amounts owed to vendors, starting with payments to the Fund Executive Director and the Municipal Reinsurance Health Insurance Fund.

b. For members that continue to maintain membership in the Fund and in the medical line of coverage, the total net supplemental assessment such members shall be payable in equal monthly installments over a three-year period beginning on March 1, 2026 and ending on February 29, 2028. However, payment may be expedited by the Fund when and if the cash balance falls below a half a month's claims exposure.

c. Members may qualify for a 10% discount of the supplemental assessment if a payment is made in the amount no less than 3 months owed by June 30, 2026

d. The rate of interest on a late supplemental assessment installment is 10% as directed in the Cash Management Plan.

BE IT FURTHER RESOLVED that copies of this resolution shall be sent to each Fund Commissioner, each Governing Body or School Board, the New Jersey Department of Banking and Insurance, and the New Jersey Department of Community Affairs.

INTRODUCED: January 15, 2026

SCHEDULED PUBLIC HEARING AND ADOPTION: February 19, 2026

BY:_____

CHAIRPERSON

ATTEST:

_____

SECRETARY

RESOLUTION NO. 14-26

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION TO OFFER MEMBERSHIP

WHEREAS, the **Metropolitan Health Insurance Fund** held a Public Meeting on **January 15, 2026** for the purposes of conducting the official business of the Fund; and

WHEREAS, the Executive Director and Actuary of the Fund has reviewed the risk, underwriting detail, and actuarial projections for the City of Paterson and Passaic City and recommend an offer of membership; and

WHEREAS, the Executive Committee has reviewed the following new member submissions and has approved membership to the following entities that will submit a fully executed Indemnity and Trust agreement to join the Fund:

1. City of Paterson – on or around 2/1/2026 – Medicare Advantage
2. Passaic City – on or around 2/1/2026 – Medicare Advantage

BE IT RESOLVED, it has been determined that the admission to membership in the Fund of the above mentioned entities would be in the best interests of the Fund and the inclusion of the entity in the Fund is consistent with the Fund's By-laws;

BE IT RESOLVED, that the Metropolitan Health Insurance Fund hereby offers membership to the above mentioned entities for Medicare Advantage coverage contingent upon receipt of the Fund's authorizing resolution to join the Fund and its executed Indemnity and Trust agreement.

ADOPTED: January 15, 2026

BY:_____

CHAIRPERSON

ATTEST:_____

SECRETARY

RESOLUTION NO. 15-26

METROPOLITAN HEALTH INSURANCE FUND
APPROVAL OF THE DECEMBER 2025 AND JANUARY 2026 BILLS LIST

WHEREAS, the **Metropolitan Health Insurance Fund** held a Public Meeting on **January 15, 2026** for the purposes of conducting the official business of the Fund; and

WHEREAS, The Treasurer for the Fund presented bills lists to satisfy outstanding costs incurred for operating the Fund during the month of December 2025 and January 2026 for consideration and approval of the Executive Committee and

WHEREAS, a quorum of the Commissioners was present thereby conforming with the Policies and Procedures of the Fund to conduct official business of the Fund,

NOW THEREFORE BE IT RESOLVED the of the Metropolitan Health Insurance Fund hereby approve the Bills List for December 2025 and January 2026 prepared by the Treasurer of the Fund and duly authorize and concur said bills to be paid expeditiously, in accordance with the laws and regulations promulgated by the State of New Jersey for Insurance Funds.

ADOPTED: January 15, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

APPENDIX I

METROPOLITIAN HEALTH INSURANCE FUND
MINUTES
OPEN MEETING: November 10, 2025
CONFERENCE CALL – ZOOM
12:00 P.M.

Meeting called to order by Chair Mundell. The Open Public Meeting Notice was read into the record.

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

Jenny Mundell, Chairwoman	Bloomfield Public Library	Present
Kimberly Duva, Secretary	Bloomfield Township	Present
Cameron Cox, Executive Committee Member	Plainfield Public Schools	Absent
Nicole Baltycki, Executive Committee Member	West Caldwell Township	Present
Chris Hartwyk, Executive Committee Member	City of Orange	Absent
Margaret Heisey, Executive Committee Member	Scotch Plains Twp	Present
Patrick Wherry, Executive Committee Member	Maplewood Township	Present

APPOINTED OFFICIALS PRESENT:

Executive Director/ Administrator	**PERMA Risk Management Services**	Brandon Lodics Emily Koval John Lajewski
Fund Coordinator	**Eagle Rock Management Group**	Joseph DiVincenzo Jennifer McHugh Thomas Kelly
Attorney	**Antonelli Kantor Rivera**	Asia Hartgrove Ramon Rivera
Treasurer	**Point Accounting Group (Formerly Laracy Associates)**	Matt Laracy
Third Party Administrator	**Aetna**	Jason Silverstein
Dental Claims Administrator	**Delta Dental of NJ, Inc.**	Crista O'Donnell
Auditor	**Donohue, Gironda, Doria & Tomkins**	Absent
Actuary	**John Vataha**	Absent
RX Administrator	**Express Scripts**	Charles Yuk

Others Present:

Jim Rhodes	Tom Fletcher	Julie Servidio
Jordyn Robinson	Lisa Narcise	Crystal Bailey

Matt Rudman	Susan Sandelli	Alysa Sauchelli
Imelda Mora	Nile Clements	Jacob Krakower
Elizabeth Dash	Lindsay Klein - Acrisure	Jackie Ortiz
K Capriglione	Katherine Polanco	
Carrie Specht	Joe Graham	

CORRESPONDENCE – None

APPROVAL OF MINUTES: September 18, 2025, October 3, 2025 and October 29, 2025

Motion: Commissioner Wherry
Second: Commissioner Baltycki
Vote: All In Favor

EXECUTIVE DIRECTOR'S REPORT

FAST TRACK FINANCAL REPORT – Mrs. Koval presented the financial fast track report, noting that the Finance Committee would meet later in the week to discuss ongoing financial challenges, particularly losses stemming from the 2024 fund year. She highlighted a significant claim related to the No Surprises Act, which amounted to over $500,000 and continued to impact the fund's results. The committee is working with Aetna to analyze these claims further before making recommendations. Mrs. Koval explained that corrective actions are being considered, including options to address deficits from both the 2024 and closed years. The proposed 2026 budget includes provisions for surplus regeneration, and the Finance Committee will finalize decisions after Thanksgiving, with information to be distributed to commissioners in advance.

Mrs. Koval also shared positive news regarding the BMED Fund, which had implemented similar out-of-network benefit changes earlier than the Metro Fund. Early data indicates improved in-network utilization and financial performance, and it is hoped that similar trends will emerge for the Metro Fund. Updates will be provided as more data becomes available.

BUDGET ADPOTION - Mrs. Koval introduced the public hearing for the 2026 budget, noting minor changes to the expense line to accommodate increased workload for the fund treasurer due to new members. These adjustments did not affect the bottom line, and the rates issued to brokers and commissioners can be considered final if the budget is approved.

Chair Mundell asked for questions from commissioners prior to opening the hearing. Commissioner Duva inquired whether the pricing for the Wellness Committee's RFPs was included in the budget, specifically referencing the Guardian Nurses program. Mrs. Koval confirmed that sufficient funds were allocated for the first year, but additional costs for an extra nurse would only arise if membership increased significantly. Commissioner Duva expressed concern about transparency, noting that the number of covered lives was expected to double, potentially requiring an additional nurse and doubling the cost. Mrs. Koval clarified that the current budget only covers one nurse, and any decision to expand would require further discussion and possible budget amendment.

Fund Coordinator asked whether the contract could be terminated after one year if surplus regeneration became a higher priority. Mrs. Koval confirmed that all contracts include a 90-day termination clause. Further discussion ensued regarding the projected increase in covered lives and the associated costs, with input from Commisisoner Wherry and Mr. Lodics. Mr. Lodics explained that the budget is based on the population at the time of adoption, and future growth would be absorbed through underwriting and expense load adjustments. He also noted that budgets can be amended within a 5% margin.

Chair Mundell summarized the discussion, confirming that the budget reflects current membership and that any additional costs due to growth would be shared among new members. Commissioner Duva agreed, emphasizing the importance of transparency for commissioners voting on the budget.

MOTION TO OPEN THE PUBLIC HEARING ON THE 2026 BUDGET

Motion: Commissioner Wherry
Second: Commissioner Baltycki
Vote: 5 Ayes, 0 Nays

MOTION TO CLOSE THE PUBLIC HEARING ON THE 2026 BUDGET

Motion: Commissioner Wherry
Second: Commissioner Baltycki
Vote: 5 Ayes, 0 Nays

MOTION TO ADOPT RESOLUTION 27-25 APPROVING THE 2026 METROPOLITAN HEALTH INSURANCE FUND BUDGET IN THE AMOUNT OF $106,640,018

Motion: Commissioner Wherry
Second: Commissioner Heisey
Vote: 5 Ayes, 0 Nays

Mrs. Koval stated that the budget would be filed with the state and that rates would be sent to WEX for benefit administration. She reminded members to make invoice payments on time and confirmed that January bills would be issued on the usual schedule.

EMERGENCY PROCURMENT RESULTS – TPA - Mrs. Koval reported that, following authorization at the previous meeting, the fund administrator, QPA, and attorney completed the emergency procurement process for medical TPA services. Aetna submitted a proposal matching the adopted budget, and all compliance documentation was received. Mrs. Koval confirmed that contract amendments would be prepared for signature.

MOTION TO APPROVE RESOLUTION 28-25 TO AWARD THE AETNA CONTRACT FOR 2026

Motion: Commissioner Wherry
Second: Commissioner Heisey

Vote: 5 Ayes, 0 Nays

2026 MEETING DATES AND EXECUTIVE COMMITTEE - Mrs. Koval initiated discussion regarding the 2026 meeting schedule and the composition of the Executive Committee, suggesting the possibility of in-person or hybrid meetings and the addition of new alternates. She referenced conversations with Commissioner Wherry, who advocated periodic in-person meetings to foster collaboration among commissioners and professionals, especially given the fund's growth. Fund Coordinator supported the idea, proposing four in-person meetings throughout the year, with Maplewood offering to host. The committee agreed to explore suitable dates and locations, with technology available for remote participation as needed. Mrs. Koval stated that nominations for new executive committee members and alternates would be solicited prior to the January reorganization meeting.

PROGRAM MANAGERS REPORT - Mr. Lajewski began his report by reminding members that open enrollment for the 2026 program year had ended, and all changes should be completed in the WEX system by November 21 to ensure timely delivery of identification cards. He provided updates on coverage changes, including the implementation of a new out-of-network fee schedule and the development of a monthly report to monitor its impact. The initial data is immature, but ongoing tracking will provide insight into utilization trends.

Mr. Lajewski discussed the 2026 National Preferred Formulary, noting that brokers would receive updated formulary and exclusion lists for distribution. He highlighted that ten members would be impacted by drugs moving from preferred to non-covered status, and two by non-preferred drugs becoming non-covered. All affected members will receive advance notification and alternative medication options.

He also reviewed the Save-On program, reporting $69,134 in savings for the first half of 2025, primarily in inflammatory conditions, asthma/allergy, and cancer. The Encircle program for GLP-1 weight loss medications is being closely monitored in partnership with Express Scripts, with reporting to validate outcomes forthcoming.

From a legislative perspective, Mr. Lajewski noted the transition of the No Surprises Act administration from federal to state oversight, which will result in new identification cards for all members. He concluded with an update on appeals, reporting two carrier appeals upheld and one IRO submission overturned. No questions were raised by commissioners.

FUND COODINATOR – Fund Coordinator reported on new membership activity, announcing the addition of Secaucus Township and Montclair Medicare Advantage effective January 1, 2026, with Patterson City and Passaic City Medicare Advantage joining in February or March. Old Bridge and Hillsdale Board of Education are pending for early 2026, along with North Hudson Regional Medicare Advantage. In total, approximately 1,800 new contracts are expected for 2026, reflecting strong growth for the fund. No questions were raised by commissioners.

MOTION TO APPROVE RESOLUTION 29-25 TO APPROVE NEW MEMBERSHIP FOR THE FOLLOWING ENTITIES: TOWN OF SECAUCUS, GUTTENBERG TOWNSHIP, NORTH HUDSON REGIONAL FIRE AND RESCUE AND MONTCLAIR TOWNSHIP.

Motion: Commissioner Wherry
Second: Commissioner Heisey
Vote: 5 Ayes, 0 Nays

ATTORNEY – Mrs. Hartgrove provided an update on the internal audit following the OSC's report, stating that her office is in contact with Mr. Harris, who represents the other named HIFs. The caps are expected to be submitted to the OSC on time, and further updates regarding the lawsuit against the OSC will be provided at the next meeting.

TREASURER – Mr. Laracy presented the October and November bill lists, each totaling over $1.3 million. He raised the issue of late payment interest, noting that while the fund currently does not enforce interest on late payments, the management committee may wish to consider this policy due to the increasing administrative burden as the fund grows.

APPROVAL OF RESOLUTION 30-25 OCTOBER AND NOVEMBER 2025 BILLS LIST

Motion: Commissioner Wherry
Second: Commissioner Duva
Vote: 5 Ayes, 0 Nays

AETNA – Mr. Silverstein reviewed the September claims, reporting $6,588,652 in total claims for 2,405 employees, equating to $2,740 per employee per month. Six high-cost claims exceeded $100,000, totaling $760,136.99. Dashboard metrics indicated strong performance across all service goals.

EXPRESS SCRIPTS – Mr. Yuk presented the pharmacy report, noting a plan cost per member per month of $193.20 for September, representing a 10% increase from the previous year. Specialty drug costs accounted for 33.2% of total spend, with a notable increase in cancer-related expenses due to a new leukemia patient. Weight loss drug utilization remains high, with Wegovy usage declining and Zepbound increasing. Reporting on the Encircle program will be available at the next meeting.

DELTA DENTAL – No report.

OLD BUSINESS - None

NEW BUSINESS – Commissioner Wherry raised a question regarding the establishment of an appeal review panel for out-of-network claims. He requested clarification on the process to ensure commissioners can guide employees appropriately. Mr. Rhodes responded that discussions are underway with two firms, including the current medical appeal firm, to handle administrative appeals. One appeal has been processed and granted, and a formal process is expected to be in place by January. Commissioner Wherry asked how the recent appeal was approved without a formal process, and Mr. Rhodes explained that it was a straightforward case involving a child and a small

dollar amount. The fund aims to balance providing benefits with cost control and will finalize arrangements for the panel soon.

PUBLIC COMMENT - None

MOTION TO ADJOURN THE MEETING:

Motion: Commissioner Heisey
Second: Commissioner Wherry
Vote: All in Favor

MEETING ADJOURNED

NEXT MEETING: December 18, 2025 12:00PM

Zoom

_____
Jordyn Robinson, Assisting Secretary

for

_____
KIMBERLY DUVA, SECRETARY

APPENDIX II

Metropolitan Health Insurance Fund
Finance Committee Meeting Minutes
Date: November 12, 2025 - TEAMS

Participants:
Cameron Cox, Committee Chair
Nikole Baltycki, Committee Member
Patrick Wherry, Committee Member
Matt Laracy, Fund Treasurer
Joseph DiBella, CSB
Tammy Brown, PERMA
James Rhodes, PERMA
Brandon Lodics, PERMA
Emily Koval, PERMA
Jordyn Robinson, PERMA

Fund Deficit and Cash Position Review

The Finance Committee meeting began with a comprehensive review of the Metropolitan Health Insurance Fund's current financial status, led by Mr. DiBella, Mr. Rhodes, Mr. Lodics, Mr. Laracy, and Mr. Cox. The committee discussed the fund's deficit of approximately $9 million as of July 31, 2025, with only $3.6 million in cash on hand—an amount sufficient to cover roughly one month of claims. Mr. DiBella explained that this precarious position was due to a surge in healthcare costs, large claims, and the impact of the No Surprises Act, which had resulted in several unexpected, high-value payments, including an $800,000 claim in August. Mr. Laracy described the manual weekly payment process to Aetna, implemented to manage limited cash resources, and noted that the apparent cash balance could be misleading due to early payments from certain entities. Mr. Lodics and Mr. DiBella emphasized that best practice for a fund of this size is to maintain at least one to one and a half months of claims in surplus, or about $6–7 million, highlighting that the current situation was extremely tight and required immediate action.

Supplemental Assessment Options and Recommendations

Mr. DiBella, Mr. Lodics, and Mr. Rhodes presented three scenarios for a supplemental assessment designed to replenish the fund's surplus and ensure reliable payment of claims. The committee reviewed options to collect $6.1 million, $7 million, or $8.9 million over a 48-month period, ultimately recommending the $6.1 million scenario as the preferred approach. This option was deemed sufficient to restore the fund's surplus to a safe level without placing undue burden on member entities. Mr. Lodics explained that the assessment would be allocated based on each entity's participation during the deficit period, ensuring fairness and that new members would not be responsible for prior deficits. The committee agreed to offer flexible payment plans, allowing entities to pay their share in a lump sum or over a shorter period if desired, and discussed the possibility of a cash discount for early payment, pending regulatory review. Mr. Wherry and other members stressed the importance of clear communication regarding how the assessment is calculated, which years are included, and the fact that only participating entities are responsible for their share, to prevent confusion among members.

Future Financial Planning and Monitoring

Ms. Brown, Mr. DiBella, and Mr. Rhodes outlined ongoing and new measures to monitor claims and financial performance more closely, aiming to prevent future deficits and promote long-term fund stability. Mrs. Brown described the implementation of a data warehouse and regular claims utilization reviews, which will enable the team to track emerging trends and compare actuals to budgeted figures, thereby reducing the likelihood of future surprises. The committee is also working with internal actuaries to enhance predictive modeling, leveraging new data tools to better forecast claims and proactively adjust budgets. Mr. DiBella and Mr. Rhodes emphasized the need for frequent Finance Committee meetings and vigilant oversight in the coming years, given the volatility in healthcare costs and the potential for large, unexpected claims.

Implementation Timeline and Next Steps

The committee, led by Mr. DiBella and Mr. Cox, agreed to develop and circulate revised supplemental assessment options and payment schedules by the following Monday, providing members with time to review and offer feedback before the next meeting. Mrs. Brown and Mr. Rhodes committed to delivering these updated materials promptly. The group scheduled a follow-up Finance Committee meeting for November 24th to finalize recommendations and prepare a memorandum for the full board of commissioners.

Member Questions and Concerns

During the meeting, Mr. Wherry, Mr. Cox, and Mrs. Baltycki raised questions regarding the timing of the supplemental assessment, its impact on municipal budgets and employee premiums, and the need for clear documentation. Mr. Wherry expressed concern about the timing of the assessment relative to open enrollment and the inability to adjust employee premiums, to which Mr. DiBella responded that the rapid emergence of large claims had made earlier notice impossible. Mr. Wherry also requested that the memo and supporting documents clearly state that only entities participating during deficit years are assessed, and that closed years do not affect new members. Mr. Lodics and Mr. DiBella agreed to clarify these points in the documentation. The committee further discussed how future surpluses or dividends would be shared and how any remaining assessment balances would be handled if the fund's financial position improves.

APPENDIX III

Metropolitan Health Insurance Fund
Finance Committee Meeting Minutes
Date: November 24, 2025 - TEAMS

Participants:
Cameron Cox, Committee Chair
Nikole Baltycki, Committee Member
Patrick Wherry, Committee Member
Joseph DiBella, CSB
James Rhodes, PERMA
Brandon Lodics, PERMA
Emily Koval, PERMA
Jordyn Robinson, PERMA

Fund Deficits and Financial Position
The committee began by reviewing the current financial position of the Metropolitan Health Insurance Fund, as outlined in the agenda. The Fund is experiencing a significant deficit, with a position of $9.4M as of July 31, 2025, and cash on hand of $3.6M, which is less than half of one month's estimated claims. The breakdown of deficits by fund year was discussed, including closed years at $492,857, 2024 at $6.6M, and 2025 through July at $2.2M. Mr. Lodics referenced these figures during the meeting, noting that the assessment options under consideration were designed to address these shortfalls. The committee acknowledged the key drivers of the deficits, including out-of-network utilization, market challenges such as the No Surprises Act, high claimant increases, inpatient stays, and the impact of GLP-1 weight loss medications. The City of Orange's claims experience was highlighted as a major contributor to the deficit, with claims far exceeding budgeted expectations until their exit from the Fund in late 2024.

Out-of-Network Utilization and Associated Fees
Discussion focused on the persistent challenge of out-of-network utilization, which has historically accounted for approximately 30% of Metro's medical claims cost—double the average for comparable funds. The committee reviewed the impact of providers marketing directly to public sector employees and the resulting high claims, particularly in April 2025. Mr. Lodics explained that the Fund had taken corrective action by capping certain out-of-network procedures at the in-network level and implementing a new fee schedule effective August 31, 2025. This adjustment, setting payment allowances at 150% of Medicare for facilities and 175% for professionals, was expected to reduce out-of-network spend and associated fees. The committee agreed that these measures should help stabilize future claims costs and improve the Fund's financial position.

Market Challenges: No Surprises Act, High Claimants, Inpatient Stays, and GLP-1 Medications
The committee discussed the impact of the No Surprises Act, which has led to substantial unintended consequences for self-funded health plans due to the flawed Independent Dispute Resolution process. Mr. Rhodes elaborated on the backlog in federal arbitration and the significant reversals and repayments required for claims dating back to 2022, which were not anticipated in budget projections. The committee noted that Aetna had invested in additional claims processors to manage the increased volume, resulting in higher paid claims in 2025. Other market challenges included an increase in high claimants over $100,000, rising inpatient stays contributing to 30% of medical spend, and the growing use of GLP-1 medications, which accounted for about half of the prescription increase. The Omada program, adopted in Q3 2024, was mentioned as a mitigating factor for some of these trends, though costs remained material.

City of Orange Claims Experience

The committee reviewed the claims experience of the City of Orange, which was the second largest member of the Fund in 2023 and 2024. Mr. Lodics presented data showing a dramatic increase in claims beginning mid-2023, with monthly averages nearly doubling and one month reaching $1.7M. The partnership with Orange ended in November 2024, and the Fund provided mature rates to cover runout/IBNR, leaving no liability at exit. As of September 2025, Orange's claims were mostly run out, with minimal additional exposure expected for the Fund.

Corrective Measures for Stabilization
The committee discussed several corrective measures implemented to stabilize the Fund, including the out-of-network fee schedule adjustment, transition to New Jersey's No Surprises Act arbitration process effective January 1, 2026, and conservative development of the 2026 budget. Mr. Lodics explained that the new state arbitration process would reduce financial exposure by imposing strict timelines, reducing administrative fees, and providing more predictable rulings. The 2026 budget was developed using conservative trend assumptions and did not factor in expected savings from recent initiatives, with the intent to build surplus and fund appeals. The Level Pharmacy Coalition contract improvement was also expected to reduce pharmacy spending by approximately 5%, though no savings were included in the budget. The budget included a $1.5 million surplus regeneration line to further strengthen the Fund's position.

Cash Flow and Financial Relief
The committee reviewed the Fund's cash flow, noting that it was operating on a cash basis with no surplus reserves and unfunded IBNR liability. Claims had run higher than budget month over month, particularly in early 2025 due to NSA catchup and out-of-network billing. PERMA and MRHIF had delayed collecting their fees for 2025 to support the Fund's cash position, with liabilities expected to reach $2.5M to MRHIF and $936,000 to PERMA by year-end. Mr. Lodics emphasized the importance of timely payment by members to sustain claims and maintain financial stability.

Supplemental Assessments: Rationale and Options
The committee discussed the rationale for supplemental assessments, as permitted by the Fund's bylaws, to steady cash flow, close out liabilities, and contribute to surplus generation. Mr. Lodics clarified that supplemental assessments were needed to relinquish unfunded liabilities, including IBNR and amounts owed to MRHIF and PERMA. The additional cash influx would protect monthly claims performance while plan initiatives took effect. All supplemental assessments would be allocated to participating members based on applicable fund year deficits, with new members exempt from prior year assessments.
Three scenarios for supplemental assessments were presented:

1. $6.1M – Majority of 2024 deficit
2. $7M – All of 2024 deficit and a portion of closed year deficits
3. $8.9M – Full 2024 and closed year deficits

Mr. Lodics explained that collection would begin in January 2026, with billing taking effect no later than March 1, 2026. The collection period could extend up to 36 months, with payments apportioned in 12, 24, or 36 equal increments. Alternatively, entities could satisfy 90% of their assessment within the first three months to have their liability considered settled. The committee discussed the merits of each option, with consensus forming around option two ($7M) as the most balanced approach.

Payment Plan Structure and Member Questions
Committee members raised questions regarding the practicality of the 36-month payment plan, the impact of early lump sum payments, and the mechanism for refunds if claims performance improved. Mrs. Koval explained that entities paying upfront could receive prorated refunds or retain excess as surplus for future use. Mr. DiBella confirmed that surplus would be kept on the Fund's books for access as needed. Mr. Cox

requested that the memo to the executive committee clearly outline payment options with specific calendar dates, including the timeline for presenting to the full Board of Commissioners, the 30-day cooling-off period, and the window for qualifying for the 10% discount. Mr. Lodics agreed to work backwards from the executive committee meeting date to establish the schedule.

Consensus and Next Steps
The committee reached consensus in favor of option two ($7M) for supplemental assessments, with Mr. Wherry and Mrs. Baltycki expressing preference for this option. Mr. Cox supported the recommendation, noting its importance for improving the Fund's financial health. Mr. Lodics commended the committee for its prudent approach and confirmed that the recommendation would be presented to the executive committee, eliminating options one and three. The committee agreed to update assessment tables and exhibits for clarity and continue monitoring claims performance and stop loss reimbursements to refine deficit projections.

APPENDIX IV

METROPOLITAN
HEALTH INSURANCE FUND

To: Metropolitan HIF Commissioners and Risk Managers

From: PERMA Risk Management Services

Date: December 18, 2025

Subject: **Metropolitan Health Insurance Fund Financial Position as of July 31, 2025**

The Metropolitan Health Insurance Fund (Metro) has continued to experience large unanticipated claims payments and associated fees that have resulted in the need for an influx of cash from the member entities to sustain the 2026 plan year and alleviate liabilities from prior plan years. We reviewed the suggested actions necessary to correct these issues with the Finance Committee on November 12th and November 24th and the ideas, suggestions and recommendations from the committee have been added to this memorandum.

Provided for your reference is an overview of the current state of the Fund and required actions associated with the current financial state of Metro. This is consistent with what was discussed with the Finance Committee.

Fund Deficits – As of July 31, 2025, the Metro's deficit position is ($9.4M) and cash on hand is $3.6M, which is less than half of 1 month of estimated claims.
Deficit by Fund Year:

Closed Years – ($492,857)

2024- ($6.6M)

2025 (Through July) – ($2.2M)

The Fund Actuary developed the initial 2025 medical claims budget utilizing claims through July 2024; with the removal of the City of Orange who has significantly contributed to the deficits above. For discussion with the Fund the following are key drivers to the deficits and challenges facing the Metro.

1) **Out of Network Utilization and Associated Fees**
2) **2024 & 2025 Market Challenges**
    a. **No Surprises Act**
    b. **High Level Claimant Increase**
    c. **Inpatient Stay**
    d. **GLP1 – Weight Loss Medications**
3) **City of Orange**

Utilization and Claims Drivers

1. **Out of Network Utilization**

In the beginning of 2024, the Fund took action to cap certain out of network procedures at the in-network level. For Metro HIF these procedures resulted in $3M+ of unanticipated paid claims for very few patients. As we saw from other Funds, Metro and its members were targeted by out-of-net network providers who understand the rich level of benefits. Providers such as these are marketing directly to public sector employees and their families and not requiring collection of out-of-pocket expenses. Often creating a benefit richer than the in-network equivalent.

The challenges of out of network spend and utilization continue to impact the Metro. On overage out of network spend makes up roughly 15% of claims for our comparable northern New Jersey Funds. Metro's out-of-net network utilization has historically been around 30% of medical claims cost with roughly $1M in out of network paid claims in April 2025. Out of network utilization and the rise of out of network utilization creates real budget challenges as the year over year trend is immensely larger than industry trend.

The most common utilized out of network providers in the Metro are chiropractors, physical therapists, outpatient surgeons/surgery centers and acupuncture, all of which Aetna has a robust network of available in network providers within the Metro footprint.

Associated with out of network utilization is Aetna's National Advantage Program (NAP), which works on the Fund and its members' behalf to negotiate discounted costs off billed charges, Aetna receives 40% of the delta in the negotiated rate and billed charges.

2. **2024 & 2025 Market Challenges**

    a. **No Surprises Act (NSA)** The NSA took effect on January 1, 2022, aiming to protect patients from surprise medical bills—especially in emergency or out-of-network (OON) situations. While it has successfully reduced balance billing for consumers, the law's implementation has caused substantial unintended consequences for self-funded health plans, particularly due to the flawed

Independent Dispute Resolution (IDR) process. Originally, the Qualified Payment Amount (QPA), the median in-network rate, was intended to serve as the benchmark in payment disputes. However, court rulings have weakened their role, allowing arbitrators to prioritize subjective factors like provider experience or case complexity. The result: rising award levels far above market norms.

Due to the complexities of the administration of the legislation there was a significant backlog in the Federal Arbitration system. In recent months all the HIFs have experienced a significant number of claims dating as far back as 2022 being reversed and repaid for significant multiples often more than 5-10Xs the initial processing in recent 2025 months. Aetna confirmed that to keep up with the significant recent Arbitration rulings, they invested in claims processors, which resulted in significant paid increases in plan year 2025.

For example, as part of the May 2025 medical claims payment the Metro had an NSA claim for a service rendered in 2022, which initially processed and paid for $12,000 reprocess and pay for $180,000.

Due to the long tail of these and the significance of the reversals, they are not anticipated in the budget projections. As of June 10, 2025, Metro HIF had roughly $3M in NSA Arbitration ruling additional payments.

b. **The number of high claimants** over $100,000 but under specific retention at the MRHIF level was greater than what had been observed in prior years. These claims' costs are borne solely by the Fund with no reimbursement from the MRHIF.

c. **Inpatient Stays** have increased and contributed 30% of the medical spend last year.

d. **GLP-1 Utilization** has increased significantly over the past year, contributing approximately 50% of the prescription increase. These drugs are expected to be approved for additional indications, which will likely continue to drive increased prescription fills. Although the Omada program was adopted in Q3 2024 has helped reduce some of the trends associated with these medications, the cost associated are material.

3. **City of Orange**

In Plan Years 2023 and 2024, the City of Orange was the 2nd largest member of the Metro. Due to unprecedented rises in utilization, out of network shift and a predatory out of network provider City of Orange saw their claims deteriorate significantly.

A three-year summary of Orange's performance reveals increases in claims utilization emerging Mid-Year 2023. The average claims cost from **January 2023 through May 2023** was **$1.1 Million per month**. The team identified an immediate claims spike beginning June 2023 and continuing through December 2023 where claims have essentially doubled resulting in a monthly average claim of **$1.935 Million or a 76 % increase** during the 2023 performance year. In the last 12 months, July 2023 through June 30, 2024, Orange's paid claims

were on average $784K above their claims budget. One month was as high as $1.7M. This unexpected and aberrant claims utilization significantly exceeds anticipated claims fluctuations.

Incurred Year	Loss Ratio	Over Budget
Plan Year 2023 (As of 5/31/2025):	151%	$5.85M
Jan 1- Nov 30, 2024 (As of 5/31/2025)	136%	$3.8M

In a partnership with Metro, Orange found an alternative solution to benefit delivery and removed their medical coverage as November 30, 2024. As a part of the HIF value proposition, entities are provided "mature," rates in which any runout/IBNR is considered leaving no liability at exit. Consistent with their performance, the Orange runs out of $1.9M or 1.75 months of budgeted claims, which has additionally impacted on the cash position of the Metro. As of September 30, 2025, Orange's claims are mostly run out with little to no expected additional exposure for the Fund.

Corrective Measures for Stabilization

1. **Out of Network Fee Schedule Adjustment –** Effective August 31, 2025, the Metro HIF through resolution mandated the out of network fee schedule for payment allowance be updated to 150% of Medicare for facilities and 175% of Medicare for professionals. This has had an immediate impact on the NAP fees from Aetna with August and September fees averaging (-$3.32) per employee per month. As claims incurred for August and later begin to process the Metro will see the out of network impact reducing as the base payment level is decreased and more members transition in network.

2. **No Surprises Act (NSA) Transition-** Effective January 1, 2026, the HIFs will be transitioning to New Jersey's NSA arbitration process, reducing the exposure to the Federal. The State's version of the legislation lessens the financial exposure to the HIFs:

    a. Only one Independent Dispute Resolution (IDR) vendor.
    b. Impose strict timelines for arbitration filing.
    c. Reduces administrative fees.
    d. Provides more predictability in arbitration ruling with fee schedule-based approach.

3. **2026 Budget Development-** Understanding the challenges Metro HIF and the public sector market is faced with, Metro HIF developed their budget conservatively with the intent of producing surplus. Claims through June 30, 2025, were utilized for budget and certain expected performance improvements were not considered for the purpose of stabilizing the claims account.

    a. **Trend Assumptions –** Medical 11% and prescription 13.5% were the trends utilized by the Actuary to develop 2026 claims budgets. These are appropriate and reflect Metro's experience since inception.
    b. **Out of Network Fee Schedule-** The claims experience used by the Actuary were for claims incurred prior to the reduction in the fee schedule. No savings assumptions were considered in the development of the 2026 budget, with the intent to build surplus and fund the appeals process.

c. **Level Pharmacy Contract Improvement-** Annually, the Level Pharmacy Coalition, which the MRHIF entities are a member of undergoes a market check in which the Coalition produces improved pricing. The 2026 improvements are expected to reduce pharmacy spending by ~5%. No savings assumptions were considered in the pharmacy budget development.
d. **Surplus Regeneration –** 2026 Budget includes a $1.5 million surplus regeneration line.

4. **New Member Addition and Underwriting –** With the challenges faced by the State Health Benefits Plan (SHBP) and the health insurance market, the HIF has become an attractive option for public entities seeking options. Metro HIF has had a healthy and steady flow of inquiries and has received commitments to join. The market has allowed our Underwriters, Actuaries and Business Development professionals to be selective and conservative in proposal development. The Fund has been able to deliver attractive proposals with margin and conservatism intended to support the financial position of Metro HIF.

5. **Cash Flow *(Exhibit B)* –** As of September 30, 2025, the Fund is operating on a cash basis with no surplus reserves and unfunded incurred and not reported (IBNR) liability and because of market challenges claims have run higher than budget month over month, particularly in the early part of 2025 with the NSA catchup and egregious out of network billing and fees.
Financial Relief- PERMA and MRHIF have delayed collecting their fees for 2025 to support the cash position of the Fund. The estimated liability at the end of 2025 will be $2.5M to MRHIF and $936,000 to PERMA. PERMA in effect has worked for no pay this past year to help the Fund. The amount suggested to be re-paid to the Fund's balance sheet will allow the Fund to pay PERMA amounts owed without interest.

   Our Fund Treasurer has done an excellent job of staying on top of the cash flow of the Funds and working with our entities to ensure timely payment. ***It is important that our members continue to pay their invoices timely to continue to sustain claims.***

<u>Supplemental Assessments</u>

The Bylaws of Metro HIF allow for the Executive Committee by majority vote to levy on the participating local units additional assessments, whenever needed to supplement the Fund's Claim Loss Retention or Administrative Accounts to assure payment of the Fund's Obligations. As of July 31, 2025, the closed years, plan year 2024 and 2025 are operating at losses.

In concert with the Finance Committee, we are recommending the Fund declare a supplemental assessment to reduce the losses experienced in 2024 and prior plan (closed) years to support the 2026 budget initiative of generating surplus. The Fund may consider in the future evaluating the 2025 plan year and taking additional action if deemed appropriate at that time.

1. **Surplus –** The Fund's current position is unstable. The recommended best practice is to hold at least 1 month of claims liability as a backstop in aberrant times. Reducing the lost revenue from prior Fund Years by applying supplemental assessments to extinguish past liabilities is an imperative step. The Fund currently is operating on a cash basis with no surplus.
2. **Liabilities –** The Fund has unfunded liabilities in which Supplemental Assessments are needed to relinquish.

a. **Incurred But Not Reported (IBNR) –** Annually, the Fund Actuary develops an expected IBNR liability, which the Fund books and accrues throughout the year as claims runout materializes. Metro HIF's IBNR is not currently supported by cash.
b. **MRHIF and PERMA –** the MRHIF and PERMA have delayed the collection of their fees in 2025; the combined amount is expected to be $3.4M at the end of the year.

3. **Cash –** As the Fund continues to work towards improved claims performance, contracts, and budget stability the additional cash influx generated from Supplemental Assessments will further protect the monthly claims performance of the Fund, while plan initiatives, such as the out of network fee schedule materialize.

All Supplemental Assessments shall be allocated to the participating member local units by participation in applicable Fund year deficits and shall be apportioned by the year's assessments. For those entities that joined the Fund in 2024, they would not share any assessment declared in prior years.

The Finance Committee is recommending a $7M Supplemental Assessment, of which we believe is adequate and justified. We are recommending the Fund begin collection of the Supplemental Assessments following adoption in January 2026. The billing of required amounts would take effect no later than March 1, 2026. The 2026 budget is developed to be self-sustaining and further contribute to surplus regeneration. As this is the case, we would be comfortable with the collection period going as far as 36 months from the start date. If the Fund position improves to a level of adequacy and comfort prior to the end of the 36-month period, the Executive Committee has the discretion to suspend the remaining payments/assessments.

Alternatively, if a group can satisfy 90% of their adopted supplemental assessment by June 30, 2026, the Fund will consider the liability satisfied. This assumes the following schedule of events:

5) ***Introduction of Supplemental Assessment: December 18, 2026***
6) ***Adoption and early collection of Supplemental Assessment: January 15, 2026***
7) ***Initial installments begin: March 1, 2026***
8) ***Final installments due no later than February 29, 2028***

For illustrative and budgeting purposes, the assessments are provided in 12, 24 and 36 equal increments by entity.

As we are expecting the market to return to some level of normalcy and surplus position to improve outside of this initiative, if the Fund finds itself in a more favorable financial position the collection of Supplemental Assessment liability can be suspended at the discretion of the Executive Committee.

We thank the Fund Commissioners and their Risk Managers for their continued support. The Fund Professionals are continuing to monitor the cash position on a regular basis and will update the Finance Committee. Should they consider altered or new recommendations, the Fund membership will be notified.

Please do not hesitate to contact the Executive Director's team with any questions

Sincerely,

PERMA Risk Management Services

Metropolitan Health Insurance Fund
Illustrative Exhibit
$7M Supplemental Assessment
2024 Plan Year and Closed

METRO Supplemental Assessment

$7,000,000- All of 2024 Deficit and Portion of Closed Year (as of 7/31/25)

Member	GRAND TOTAL FY 2024 AND CLOSED YEAR Net surplus/ Cash Collection	Monthly payments 12 months	24 months	36 months
Bloomfield Township	$ 1,693,493.65	$ 141,124.47	$ 70,562.24	$ 47,041.49
Bloomfield Library	$ 40,883.14	$ 3,406.93	$ 1,703.46	$ 1,135.64
East Amwell	$ 5,463.74	$ 455.31	$ 227.66	$ 151.77
Maplewood	$ 304,436.45	$ 25,369.70	$ 12,684.85	$ 8,456.57
Orange	$ 1,196,389.12	$ 99,699.09	$ 49,849.55	$ 33,233.03
Plainfield BOE	$ 3,155,687.78	$ 262,973.98	$ 131,486.99	$ 87,657.99
Scotch Plains	$ 328,562.77	$ 27,380.23	$ 13,690.12	$ 9,126.74
West Caldwell	$ 275,083.76	$ 22,923.65	$ 11,461.82	$ 7,641.22
	$ 7,000,000.41	$ 583,333.37	$ 291,666.68	$ 194,444.46

Exhibit A

July 31, 2025 Financial Fast Track

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF July 31, 2025

		THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
UNDERWRITING INCOME		**7,503,761**	**50,653,628**	**207,950,683**	**258,604,312**
CLAIM EXPENSES					
Paid Claims		6,315,245	46,520,941	180,131,885	**226,652,826**
IBNR		158,060	993,526	6,202,000	**7,195,526**
Less Specific Excess		(561,319)	(2,094,689)	(5,740,079)	**(7,834,768)**
Less Aggregate Excess		-	-	-	**-**
TOTAL CLAIMS		**5,911,985**	**45,419,778**	**180,593,806**	**226,013,584**
EXPENSES					
MA & HMO Premiums		1,021,901	7,046,495	15,510,298	**22,556,793**
Excess Premiums		214,497	1,485,779	3,986,606	**5,472,385**
Administrative		528,768	3,393,853	11,349,468	**14,743,321**
TOTAL EXPENSES		**1,765,166**	**11,926,128**	**30,846,371**	**42,772,499**
UNDERWRITING PROFIT/(LOSS) (1-2-3)		(173,390)	(6,692,277)	(3,489,494)	**(10,181,771)**
INVESTMENT INCOME		9,530	139,901	603,103	**743,004**
DIVIDEND INCOME		57,191	57,191	-	**57,191**
STATUTORY PROFIT/(LOSS) (4+5+6)		**(106,669)**	**(6,495,185)**	**(2,886,391)**	**(9,381,577)**
DIVIDEND		-	-	-	**-**
Transferred Surplus IN		-	-	-	**-**
Transferred Surplus OUT		-	-	-	**-**
STATUTORY SURPLUS (7-8+9)		**(106,669)**	**(6,495,185)**	**(2,886,391)**	**(9,381,577)**
		SURPLUS (DEFICITS) BY FUND YEAR			
Closed	**Surplus**	57,191	(409,316)	(83,541)	**(492,857)**
	Cash	-	(571,909)	937,859	**365,950**
2024	**Surplus**	(223,538)	(3,831,447)	(2,802,851)	**(6,634,298)**
	Cash	(724,080)	(11,468,165)	2,904,238	**(8,563,927)**
2025	**Surplus**	59,678	(2,254,422)		**(2,254,422)**
	Cash	3,401,714	11,814,748		**11,814,748**
TAL SURPLUS (DEFICITS)		**(106,669)**	**(6,495,185)**	**(2,886,392)**	**(9,381,577)**
TAL CASH		**2,677,635**	**(225,325)**	**3,842,097**	**3,616,771**
		CLAIM ANALYSIS BY FUND YEAR			
TOTAL CLOSED YEAR CLAIMS		**-**	**505,126**	**114,524,196**	**115,029,322**
FUND YEAR 2024					
Paid Claims		592,576	11,094,356	60,757,659	**71,852,014**
IBNR		(86,828)	(5,932,213)	6,202,000	**269,787**
Less Specific Excess		(287,422)	(1,330,888)	(890,049)	**(2,220,937)**
Less Aggregate Excess		-	-	-	**-**
TOTAL FY 2024 CLAIMS		**218,326**	**3,831,255**	**66,069,610**	**69,900,864**
FUND YEAR 2025					
Paid Claims		5,722,669	34,663,646		**34,663,646**
IBNR		244,888	6,925,739		**6,925,739**
Less Specific Excess		(273,898)	(505,988)		**(505,988)**
Less Aggregate Excess		-	-		**-**
TOTAL FY 2025 CLAIMS		**5,693,659**	**41,083,396**		**41,083,396**
MBINED TOTAL CLAIMS		**5,911,985**	**45,419,778**	**180,593,806**	**226,013,583**

Exhibit B

Cash Flow Projection - 2025

2025 METROPOLITAIN	Jan, 2025	Feb, 2025	March, 2025	April, 2025	May, 2025	June, 2025	July, 2025	Aug, 2025	Sept, 2025	Oct, 2025	Nov, 2025	Dec, 2025
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Projected	Projected	Projected
Beginning Cash Balance	$ 2,904,241	5,591,655.29	6,307,947.54	6,458,399.72	3,834,657.99	3,247,812.76	573,189.17	3,250,823.91	4,117,119.15	5,448,889.01	3,892,802.51	2,698,400.41
Claim Payments - Actual	$ (6,216,176)	$ (5,320,722)	$ (5,941,016)	$ (8,211,456)	$ (7,871,429)	$ (6,416,408)	$ (6,406,522)	$ (7,691,082)	$ (7,101,695)			
Claim Payments Projected										$ (7,066,433)	$ (7,396,388)	$ (7,101,695)
NAP CREDIT ADJ								$ 2,329,588	$ -	$ 266,610		
Assessments Collected Actual	$ 9,852,457	$ 7,555,143	$ 7,776,644	$ 1,932,979	$ 2,835,856	$ 2,354,459	$ 4,605,090	$ 1,212,325	$ 1,473,712			
Assessments Billings - Estimated per Budget										$ 1,236,730	$ 2,260,248	$ 2,349,962
Prepayments/ Prepaidpaid expected to come in				$ 4,792,937	$ 5,874,643	$ 2,683,870	$ 6,066,338	$ 5,611,437	$ 6,065,116	$ 5,124,830	$ 5,124,830	$ 3,289,171
Collection of Delinquent Assessments								$ 213,155	$ 42,768			
Collection of Stop Loss/Other Receipts - COBRA	$ 252,143	$ 90,888	$ 71,979	$ 421,147	$ 96,585	$ 265,107	$ 169,431	$ 486,281	$ 2,205,396	$ 93,282	$ 30,000	$ 30,000
ESI Rx Rebates - Estimated				$ 49,572	$ 96,019	$ 53,176	$ 115,951	$ 93,815		$ 203,624	$ 214,257	$ 184,469
Interest Earned	$ 16,821	$ 15,894	$ 20,246	$ 16,520	$ 14,298	$ 7,973	$ 9,530	$ 11,779	$ 8,408	$ 15,000	$ 8,000	$ 8,000
Expenses -Paid (does not include PERMA & MRHIF)	$ (1,217,831)	$ (1,624,911)	$ (1,777,401)	$ (1,625,442)	$ (1,632,816)	$ (1,622,801)	$ (1,882,183)	$ (1,401,003)				
Expenses Projected -Excluding PERMA & MRHIF									$ (1,361,935)	$ (1,429,730)	$ (1,435,348)	$ (1,436,677)
Ending Cash Balance - Excluding PERMA & MRHIF Paymer	$ 5,591,655	$ 6,307,948	$ 6,458,400	$ 3,834,658	$ 3,247,813	$ 573,189	$ 3,250,824	$ 4,117,119	$ 5,448,889	$ 3,892,803	$ 2,698,400	$ 21,631

Claims assume 3-month average (July, August, September)

2025 METROPOLITAIN	Jan, 2025	Feb, 2025	March, 2025	April, 2025	May, 2025	June, 2025	July, 2025	Aug, 2025	Sept, 2025	Oct, 2025	Nov, 2025	Dec, 2025
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Projected	Projected	Projected
Beginning Cash Balance	$ 2,904,241	5,591,655.29	6,307,947.54	6,458,399.72	3,834,657.99	3,247,812.76	573,189.17	3,250,823.91	4,117,119.15	5,448,889.01	4,161,845.78	3,566,442.40
Claim Payments - Actual	$ (6,216,176)	$ (5,320,722)	$ (5,941,016)	$ (8,211,456)	$ (7,871,429)	$ (6,416,408)	$ (6,406,522)	$ (7,691,082)	$ (7,101,695)			
Claim Payments Projected										$ (6,797,389)	$ (6,797,389)	$ (6,797,389)
NAP CREDIT ADJ								$ 2,329,588	$ -	$ 266,610		
Assessments Collected Actual	$ 9,852,457	$ 7,555,143	$ 7,776,644	$ 1,932,979	$ 2,835,856	$ 2,354,459	$ 4,605,090	$ 1,212,325	$ 1,473,712			
Assessments Billings - Estimated per Budget										$ 1,236,730	$ 2,260,248	$ 2,349,962
Prepayments/ Prepaidpaid expected to come in				$ 4,792,937	$ 5,874,643	$ 2,683,870	$ 6,066,338	$ 5,611,437	$ 6,065,116	$ 5,124,830	$ 5,124,830	$ 3,289,171
Collection of Delinquent Assessments								$ 213,155	$ 42,768			
Collection of Stop Loss/Other Receipts - COBRA	$ 252,143	$ 90,888	$ 71,979	$ 421,147	$ 96,585	$ 265,107	$ 169,431	$ 486,281	$ 2,205,396	$ 93,282	$ 30,000	$ 30,000
ESI Rx Rebates - Estimated				$ 49,572	$ 96,019	$ 53,176	$ 115,951	$ 93,815		$ 203,624	$ 214,257	$ 184,469
Interest Earned	$ 16,821	$ 15,894	$ 20,246	$ 16,520	$ 14,298	$ 7,973	$ 9,530	$ 11,779	$ 8,408	$ 15,000	$ 8,000	$ 8,000
Expenses -Paid (does not include PERMA & MRHIF)	$ (1,217,831)	$ (1,624,911)	$ (1,777,401)	$ (1,625,442)	$ (1,632,816)	$ (1,622,801)	$ (1,882,183)	$ (1,401,003)				
Expenses Projected -Excluding PERMA & MRHIF									$ (1,361,935)	$ (1,429,730)	$ (1,435,348)	$ (1,436,677)
Ending Cash Balance - Excluding PERMA & MRHIF Paymer	$ 5,591,655	$ 6,307,948	$ 6,458,400	$ 3,834,658	$ 3,247,813	$ 573,189	$ 3,250,824	$ 4,117,119	$ 5,448,889	$ 4,161,846	$ 3,566,442	$ 1,193,978

Claims assume CY 2025 Average

2025 METROPOLITAIN												
	Jan, 2025	Feb, 2025	March, 2025	April, 2025	May, 2025	June, 2025	July, 2025	Aug, 2025	Sept, 2025	Oct, 2025	Nov, 2025	Dec, 2025
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Projected	Projected	Projected
Beginning Cash Balance	$ 2,904,241	5,591,655.29	6,307,947.54	6,458,399.72	3,834,657.99	3,247,812.76	573,189.17	3,250,823.91	4,117,119.15	5,448,889.01	3,857,540.58	2,957,832.01
Claim Payments - Actual	$ (6,216,176)	$ (5,320,722)	$ (5,941,016)	$ (8,211,456)	$ (7,871,429)	$ (6,416,408)	$ (6,406,522)	$ (7,691,082)	$ (7,101,695)			
Claim Payments Projected										$ (7,101,695)	$ (7,101,695)	$ (7,101,695)
NAP CREDIT ADJ								$ 2,329,588	$ -	$ 266,610		
Assessments Collected Actual	$ 9,852,457	$ 7,555,143	$ 7,776,644	$ 1,932,979	$ 2,835,856	$ 2,354,459	$ 4,605,090	$ 1,212,325	$ 1,473,712			
Assessments Billings - Estimated per Budget										$ 1,236,730	$ 2,260,248	$ 2,349,962
Prepayments/ Prepaidpaid expected to come in				$ 4,792,937	$ 5,874,643	$ 2,683,870	$ 6,066,338	$ 5,611,437	$ 6,065,116	$ 5,124,830	$ 5,124,830	$ 3,289,171
Collection of Delinquent Assessments								$ 213,155	$ 42,768			
Collection of Stop Loss/Other Receipts - COBRA	$ 252,143	$ 90,888	$ 71,979	$ 421,147	$ 96,585	$ 265,107	$ 169,431	$ 486,281	$ 2,205,396	$ 93,282	$ 30,000	$ 30,000
ESI Rx Rebates - Estimated				$ 49,572	$ 96,019	$ 53,176	$ 115,951	$ 93,815		$ 203,624	$ 214,257	$ 184,469
Interest Earned	$ 16,821	$ 15,894	$ 20,246	$ 16,520	$ 14,298	$ 7,973	$ 9,530	$ 11,779	$ 8,408	$ 15,000	$ 8,000	$ 8,000
Expenses -Paid (does not include PERMA & MRHIF)	$ (1,217,831)	$ (1,624,911)	$ (1,777,401)	$ (1,625,442)	$ (1,632,816)	$ (1,622,801)	$ (1,882,183)	$ (1,401,003)				
Expenses Projected -Excluding PERMA & MRHIF									$ (1,361,935)	$ (1,429,730)	$ (1,435,348)	$ (1,436,677)
Ending Cash Balance - Excluding PERMA & MRHIF Paymer	$ 5,591,655	$ 6,307,948	$ 6,458,400	$ 3,834,658	$ 3,247,813	$ 573,189	$ 3,250,824	$ 4,117,119	$ 5,448,889	$ 3,857,541	$ 2,957,832	$ 281,063

Claims assume consistent with September

Notes:

- Cash flow projections are illustrative. Ending cash position will be reliant on actual claims spend

Cash flow projections reflect the collection of $2.3M in NAP reimbursements from Aetna in July offsetting the total claims amount.

APPENDIX III

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
OFFICE OF SOLVENCY REGULATION
PO BOX 325
TRENTON, NJ 08625-0325

TEL (609) 292-7272
FAX (609) 292-6765

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

JUSTIN ZIMMERMAN
Commissioner

November 19, 2025

TO: Metropolitan Health Insurance Fund

Attn: Jenny Mundell, Chairwoman (in care of Brandon Lodics)
Brandon Lodics, Executive Director

FROM: Carolina Chong
Insurance Examiner

RE: 2025 Health Insurance Joint Insurance Fund Questionnaire

The Department of Banking and Insurance ("DOBI") has reviewed the Fund's 2024 audit report.

Please provide responses to the following questions.

Financial:

1. If the fund has a decrease in net position from the prior year or a negative net position in the current year, please explain the cause(s).

    a) Pursuant to N.J.A.C. 11:15-3.16(b), if the fund has a negative net position, the fund commissioners shall submit to the Commissioner and the Commissioner of the Department of Community Affairs a report of the causes of the account's insufficiency, the assessments necessary to replenish it and the steps taken to prevent a recurrence of such circumstances. As such, please detail the plan to address the cause(s) of the fund's net position and any steps the fund intends to take to prevent the circumstances that resulted in the negative net position.

    b) If the fund is in a negative net position and intends to increase the annual assessment, please explain the actuarial methodology that was used to develop the rate increase.

    c) If the plan does not include any planned supplemental assessments or interfund year transfer, please explain the rationale for this position.

2. If the plan does not include an increase for the subsequent annual assessment, please explain the rationale for this position.

3. Has the fund returned dividends/refunds to members in the past three years? If so, please detail.

4. If a member has not paid an assessment, what are the fund's process to follow up with the member?

5. Do the fund's bylaws include requirements for payment of supplemental assessments for departing members? If so, please detail.

6. How does a fund's supplemental assessment or interfund year transfer impact the ability of the fund to compare rates for the subsequent policy year? Are the fund commissioners and members aware of the fund's net position in time to appropriately analyze proposed rates for the subsequent policy year?

Governance:

1. A. Pursuant to N.J.A.C. 11:15-3.6(e)3, please provide the applicable documentation as of January 1, 2025. Copies of the fund's prospective and executed agreements or contracts, and any renewal or new agreements or contracts with any administrator, servicing organization or program manager. Such agreements or contracts shall specify the duties of, and the compensation to be paid to, each such entity. Copies of the above shall be accompanied by a list of all parties having or deriving any interest, right or benefit in the servicing organization, program manager or administrator, as well as any services to be performed which are subcontracted. **Provide current agreements or contracts – do not provide Exhibit A.**

   B. In addition to A above, to the extent the terms and conditions of any renewal agreement or contract and the parties thereto remained unchanged from prior years, please indicate when the original agreement(s) or contract(s) were established.

2. A. Pursuant to N.J.A.C. 11:15-3.6(e)10, please provide a completed and updated Exhibit B for all senior officers and directors of the administrator and servicing organizations providing services to the fund in 2025. **Do not provide Exhibit C.**

   B. In addition to A above, to the extent the information contained in the data forms remained unchanged from prior years, please indicate when the original data form(s) were completed.

Please email the Fund's responses to carolina.chong@dobi.nj.gov by December 5, 2025. If there are any questions, please feel free to contact me. Thank you.

Copies to: David Wolf, Aileen Egan, William Leach [DOBI]
Michael Rogers, Nick Bennett [DCA]

Date: December 12, 2025

To: Ms. Carolina Chong, Department of Banking and Insurance, Insurance Examiner

Re: Inquiry of November 19, 2025, on the Metropolitan Health Insurance Fund financial position through 12/31/24

Dear Ms. Chong,

The Metropolitan Health Insurance Fund (the "Fund" or "Metro-HIF") is in receipt of your November 19, 2025 correspondence inquiring into the Fund's financial position through December 31, 2024. Below are the Fund's responses to your inquiry.

1. a) As of September 30, 2025, Fund Year (FY) 2024 is running at surplus deficit of $7,540,000. The Fund's Executive Committee has reviewed the challenges that the Fund saw in 2024, some of which occurred in 2025.

The following challenges surfaced, particularly in the second half of 2024:

The Hackensack-Meridian Health System's Contract – in July 2024, there was a revised hospital pricing deal with Aetna. Hackensack-Meridian Health System HMHS is the Fund's top utilized facility. This was a public and challenging negotiation for both HMHS and Aetna. These hospital negotiations are intensifying statewide. In the end, HMHS secured a material increase in reimbursement which is having a direct and immediate impact on the Fund's claim costs. Subsequently, the contract included a fee escalator effective July 1, 2025 that was unknown to the Fund as these contract negotiations are proprietary to our Third-Party Administrators.

High - Cost Claimants increased substantially and contributed up to 30% of the medical spend in 2024. In 2024, there were 37 claimants over $50,000 and the average high claimant cost $108,750.

Out of Network utilization had a significant impact on the Fund financials in 2023 and 2024. The Fund saw multiple claimants for varicose vein surgeries provided by out-of-net network facilities, costing the Fund up to $200,000 for each procedure. In February 2024, the Fund capped certain CPT codes used for varicose vein surgery that were billed by out of network providers to the average in network facility payment as a remedy to an influx of these out of network service bills. In late 2024, the Fund requested that the City of Orange leave due to the overutilization of these services performed by out of network doctors. In August 2025, to address out of network utilization the Fund universally will lower the out of network fee schedule from FAIR to a percent of the Medicare Schedule.

GLP-1 Utilization (weight loss drug) for non-type II diabetic care has increased dramatically over the past year(s). The impact of GLP-1s for weight loss has contributed to an estimated 50% of the 2025 prescription increase. These drugs are expected to be approved for additional indications, which will likely continue to drive increased prescription costs. Although a cost containment program was adopted in 2024 which should help reduce some costs borne by the Fund, it will not completely reduce utilization and cost.

No Surprises Act Claims - In addition to utilization and unit cost increases, claims resulting from the Federal Government's No Surprises Act (NSA) had a significant impact on the Fund's financials in the second quarter of 2025, for claims that were incurred in 2022-2024. Out of Network claims originally processed and included in the Fund's experience used by the Actuary to project the 2023, 2024 and 2025 budgets did not include the unforeseen NSA awards. NSA awards arbitrated years after they were incurred, were reprocessed at a much higher amount in 2025. The additional awards that the out-of-net network providers received were not considered or trended forward in these budgets. Starting in 2026 the Fund will be subject to New Jersey surprise billing system to mitigate the impact of the significant arbitration awards resulting from the federal system.

b) The Fund did not elect to increase the annual assessment in 2024.

c) The Fund will not be issuing an increase in annual assessment, rather the Commissioners are likely to issue a supplemental assessment in the amount of $7 million to address the deficit in 2024 in December. This will be filed with the appropriate State agencies.

2. To determine the FY 2024 budget, the Fund Actuary used data through June 30, 2023, and recommended a medical increase of 17.35% and prescription of 1.63%. Claims

increases began to surface in the second half of 2024, after the budget had been adopted. The Fund will issue a supplemental assessment in June 2025 and will start collecting in January 2026.

3. The Fund has never returned a dividend or rebate.

4. The Treasurer would be responsible for following up and recovering the outstanding assessments from the member entities.

5. Yes, the below excerpt has been pulled from the Fund bylaws to address surplus/deficits for terminated members:

> *A member that has been terminated or does not continue as a member of the Fund shall nevertheless share in any surplus in the appropriate trust accounts for that Fund Year pro rata according to its participation and remain jointly and severally liable for claims incurred by the Fund and its members during the period of its membership, including, but not limited to, being subject to and liable for supplemental assessments.*
>
> *Prior to the conclusion of the Fund's current fiscal year, the Fund shall provide written notification to a member that has been terminated by or withdrawn from the Fund, of the estimated surplus or estimated supplemental assessment for which the member may share or be liable pursuant to 4 above.*

6. The Fund had never issued a supplemental assessment before. The Fund Commissioners and members are aware of the Fund's net position through monthly financial reports delivered in the Fund meetings and distributed to all members. The Financial reports include cash and surplus positions for all Fund Year.

We continue to closely monitor the Fund's financial position and will escalate efforts if necessary to ensure the continued strength and liquidity of this Metro- HIF.

As for the governance, attached with this letter is a listing of the Fund professionals and their contract and bio form status. The completed documents are also included in a zip file. If there is a missing document due to a delay in a signature or legal review with the vendor, we will be diligently following up and expect to have all outstanding documents filed with DOBI by January 31, 2026.

Please let us know if you have any questions on the above response.

Respectfully submitted,

APPENDIX IV

OATH OF OFFICE

State of New Jersey

County of Essex

I, _____, do solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution of the state of New Jersey; that I will bear true faith and allegiance to the same and to the governments established in the United States and in this state, under the authority of the people and that I will faithfully, impartially, and justly perform all the duties as a member of the Executive Committee of the Metropolitan Health Insurance Fund, according to the best of my ability. (so help me God).

_____

Sworn and subscribed to

before me this (15th day of January 2026)

_____, Esquire

Attorney-at-law of New Jersey